Three a Day:

Children Having Children In Alaska

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THREE A DAY: CHILDREN HAVING CHILDREN IN ALASKA

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Maureen Weeks

Senate Advisory Council
Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

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Alaska State Legislature

Senate Advisory Council

P.O. Box V
State Capitol
Juneau, Alaska 99811
Phone: (907) 465-3114

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Alaska has the second highest adolescent pregnancy rate, the sixth highest adolescent abortion rate and the ninth highest adolescent birth rate in the United States -- which has the highest adolescent pregnancy, abortion and birth rates of any industrialized nation in the world. The state's Alaska Native adolescent birth rate is more than double the national rate for all races and it is increasing, while other state and national rates are slowly falling.

The attached report, Three A Day: Children Having Children in Alaska, describes the extent and costs of adolescent pregnancy and parenting in our state. Three teenagers a day give birth in Alaska. One a day is between 15 and 17 years old; one a month is 14 or younger. Nearly one in five of these young women are having their second, third or even fourth children. Nearly three in five are unmarried and 96 percent of unmarried U.S. teenage mothers keep their babies. Since 1984, more than 2,500 children have been born in Alaska to mothers who are still not yet 20 years old today.

STUNTED LIVES

While adolescents in Alaska are bearing and caring for children, teenagers in other countries and other states are going to school and learning the work and life skills necessary to become self sufficient adults. Girls who have babies when they hardly more than children themselves frequently become permanent dropouts from school and society, dependent on government support. Their children are at risk for early death, abuse, school failure, injury, emotional difficulties -- and teenage parenting.

The poverty, absence of goals, and sense of futility frequently spawned by adolescent childbearing are also often its causes in the next generation. The infant for whom society has sympathy today may be the child-parent society blames in a decade and a half for yet another untimely pregnancy and birth.

A PROBLEM TOO COSTLY TO IGNORE

It costs more than $12,000 a year to provide basic public services (food, medical care and essential living expenses only) to one needy teenage parent with one child. Babies born to adolescent mothers in Alaska this year alone will cost $21.5 million in public assistance (1988 dollars) by the time they reach the age of 19. Every year, it costs more than $51 million to support needy families of Alaska mothers who had their first baby when they were under the age of 20.

These are conservative cost estimates which do not include any of the public services often needed if very young parents are to become self sufficient: remedial and special education for parent and child; foster care; physical and sexual abuse counseling; child care and transportation, among others.

SOMEONE'S DAUGHTER

A 15-year-old mother lives anywhere in Alaska. She is someone's daughter, impregnated by someone's son. She is urban or rural, poor or middle class. She can be your neighbor, your babysitter, your child. The attached report describes the risk of lasting negative consequences for both mother and child and current research into the causes of teenage pregnancy. It presents a range of workable solutions already in place in other parts of the United States.

A topic so personal, so intimate, so compelling is easy to describe but difficult to control. The intimidating search for solutions generates diverse opinions and sometimes heated controversy. This report offers suggestions by state and national teen pregnancy experts, examples of recent legislation and descriptions of public and private programs from other parts of the United States. But Alaska's geographic situation and demographic blend are unique among the 50 states and the sample of programs listed here is intended only as a springboard for the ideas of those who want to attack this important social problem in Alaska.

EXECUTIVE SUMMARY

INTRODUCTION

The introduction briefly summarizes the problems facing adolescents who bear children and the public cost of supporting those who cannot support themselves. A pregnant teenage girl and her boy friend play a cameo role. The introduction includes definitions of terms.

The paper shows the extent, the causes and the consequences of untimely pregnancy and parenthood. It presents options other entities have used to deal with what most authorities label a grave and growing social problem. So personal, sensitive and immediate a topic generates diverse opinions on how to solve it. The range of these sometimes disparate proposals is presented for discussion.

Chapter I: ALASKA PORTRAIT: SOMEONE'S DAUGHTER

Teen parenting is more than a distant symbol of hopelessness in an East St. Louis slum filling the television screen between advertisements on 60 Minutes. A 15-year-old mother lives anywhere in Alaska. She is someone's daughter, impregnated by someone's son. She is urban or rural, poor or middle class. She can be your neighbor, your child, your grandchild. This chapter is a portrait of nine young Alaska women who have recently faced the inevitable decisions which come with untimely pregnancy. Among the true stories told here: A 13 year old Alaska girl was pregnant in late 1988 with her second child; both children were fathered by her own father. A 16 year old recently

gave birth to her fourth child; abused, she abuses her own children. A 17 year old with her baby in her arms learned from a public health nurse that she was pregnant again. A college-bound senior who was so drunk the world seemed "warm and fuzzy" the night she got pregnant says she saw her childhood slip away with every push on the delivery table. She isn't going to college because she can't afford it -- "plus, where would I ever find the time?"

Chapter II: THREE A DAY: ADOLESCENT BIRTHS IN ALASKA

This chapter is of a statistical nature. The statistics, summarized, include:

One in eight female teenagers in Alaska becomes pregnant. One in 17 has a baby. Between six and seven Alaska adolescents a day become pregnant. Three a day have babies. Two births a day are to 18 and 19 year olds; one a day is to a teenager between 15 and 17; one a month is to a girl age 14 or younger. Of every 11 babies born in Alaska, one is the child of an adolescent mother. About one in five Alaska adolescents who give birth have already had a baby. More than 2,500 children have been born in Alaska to mothers who are not yet 20 years old today.

In 1985, Alaska had the second highest reported teen pregnancy rate among the 50 states and the ninth highest birth rate. Among every one thousand adolescent girls, four give birth in Japan, 51 give birth in the U.S., 60 give birth in Alaska and 110 give birth among Alaska Natives. Alaska's teen birth rate is more than 80 percent higher than that of the Yukon Territory, the state's nearest neighbor. Although adolescent birth rates are falling in the nation and in Alaska as a whole, they are rising among Alaska Natives. Nearly three fifths of Alaska adolescent mothers are unmarried when they give birth. The state keeps no record of abortions but national adolescent pregnancy experts estimate that 41 percent of Alaska teen pregnancies are terminated (very close to the national average).

Chapter III: IN ALASKA: THE PUBLIC COST

Because they are at risk to lack education and job skills, teenage parents may require public assistance for a number of years. U.S., Alaska and local governments pay more than $51 million a year to support needy families of Alaska mothers who had children when they were teenagers. Of this, $4 million is spent each year to support needy parents who are still in their teenage years today. Basic costs to support one needy teen mother and her child are more than $12,000 a year. Each cohort of babies born in one year will cost the public $21.5 million (1988 dollars) by the time the group reaches age 19.

These are conservative cost estimates. They include only Aid to Families with Dependent Children, Food Stamps and Medicaid costs. They do not include costs of pregnancies which end in miscarriage or abortion or costs of intervening to prevent repeat pregnancies in young girls who may be caught in unhealthy and sometimes incestuous cycles. Nor do they include costs of educating and training a teenage mother to enter the job market, costs of child care while the mother completes her education, costs of foster care if the mother is homeless, protective services for abused adolescent mothers and their children, housing, counseling and partial loss of mother and child as productive members of society.

In one typical month, 335 Alaska teenage parents and their families receive public assistance. Because teenage parents, like other welfare recipients, move on and off the public assistance rolls, the total number of Alaska adolescent-headed families receiving welfare in a year is larger than 335. The majority of Alaska teen heads of household receiving welfare in a typical month are 18 and 19 years old and have one child.

Chapter IV: STUNTED LIVES: THE CONSEQUENCES OF ADOLESCENT CHILDBEARING

The injuries inflicted by teenage childbearing are not confined to the youthful mother and her children. They spread outward to society and forward to succeeding generations. Every child needs certain opportunities in order to become a healthy, self sufficient adult. But children born when their parents are still children themselves may miss out. Parenting is a difficult enough task for anyone; it is much harder when attempted in the poverty, isolation, depression, hopelessness, marital instability and unpreparedness which beset many very young parents. Although not all offspring born to adolescents suffer stunted lives, statistics show that as a group, they are more likely than other babies to die before their first birthday, to be hospitalized and to die as children of injuries or violence. They display more physical, emotional, behavioral and developmental difficulties than do children of older parents. They are more likely to fail in school and to score lower on standardized tests. Finally, in a phenomenon that compresses generations, children of adolescents tend to become adolescent parents themselves.

The adolescent mother is more likely than other mothers to be single, poor, isolated, depressed and a school dropout. One authority says the suicide rate among teen parents is seven times that of teens who are not parents. Teen mothers are likely to have poor math and language skills and only half attain a high school diploma. They tend to have larger families and more closely spaced children than do older parents. They may be more authoritarian and rigid than older parents. One study shows they begin conversation with, talk to and look at their infants less frequently than older mothers.

Chapter V: THE CAUSES OF ADLESCENT PREGNANCY: A DOUBLE EDGED SWORD

Too-early pregnancy and parenting are linked to poverty, low academic achievement, unsatisfactory school experiences and a feeling of futility or hopelessness. Also implicated are the influence of the media, community attitudes and lack of positive communication with parents.

Chapter VI: WANTED: "A LEADER WITH GUTS AND COURAGE"

The litany of risks facing children of very young parents -- poverty, unemployment, academic failure, futility -- is similar to the list of circumstances which threaten to lead them into precocious parenthood. Without intervention, the child for whom the public has sympathy today may be the child-parent one blames for yet another early pregnancy in a decade and a half. This chapter presents concrete suggestions by two Alaska experts and numerous national experts on combatting the problems of adolescent pregnancy. The strategies, summarized, include:

* Show disadvantaged teenagers there are options other than too-early parenting by: teaching them life skills, social connectedness and parenting; providing adult mentors as examples; reducing the school dropout rate (Alaska ranks 41st among the 50 states in rate of high school students who graduate); and making school a more meaningful and more positive experience for marginal students.

* Help teens postpone sexual activity by: encouraging sex and family life education courses; teaching assertiveness and decision making skills; involving parents in decisions. Encourage the media, with its "pervasive influence" on adolescents to alter its message. Some experts find a

strong and growing sentiment that schools can do more to help teens delay pregnancy.

* Make alternatives to child bearing available to the pregnant adolescent. These include adoption and abortion.

* Help the family of the adolescent parent. Encourage child support enforcement (at a time when states are adopting "workfare" for young mothers, it is appropriate to consider something similar for young fathers, one panel of experts says); help the mother get education and job training so she can become self sufficient; provide child care and counseling; make school meaningful for the at-risk child. The public must make up-front contributions to a population in which we have only "punily and grudgingly" invested, says one advocacy group.

* Contraceptive education: cause or cure? Many national groups urge contraceptive education and counseling for adolescents who choose to be sexually active. Several experts suggest school-based clinics to provide comprehensive health care to the "most underserved" segment of our society -- adolescents. They say clinics on or near schools have the advantage of being accessible and of attracting males (for such needs as athletic physicals) as well as females. Other advocates object that "modern" sex education classes haven't worked, that promiscuity breeds psychological and physical harm, that birth control clinics for adolescents are the latest step in a movement to transform schools into social welfare agencies and that school health clinics are destroying the old morality of family, church and neighborhood.

The section begins with an historical overview. Sexual activity among unmarried adolescents rose dramatically in the 1970's and leveled off in the early 1980's. Indeed, so many more adolescents are sexually active that the pregnancy rate among all teenage women has increased although the pregnancy rate among sexually active teenagers has decreased. Birth rates among all adolescents have fallen, while birth rates to unmarried

adolescents have increased. Adolescent abortion rates increased sharply after 1973 but increased by less than three percent from 1980 to 1985.

The arguments against making contraceptives available to adolescents are offered by Barrett Mosbacker of the Family Research Council, Dr. Dinah Richards of the San Antonio Pregnancy Centers and Allen C. Carlson of the Rockford Institute. Arguments for making contraceptives available to sexually active teens are summarized from the National Research Council, the Children's Defense Fund, the Urban Institute, the Council of State Policy and Planning Agencies, the National Governors' Association and the Alan Guttmacher Institute.

Chapter VII: IDEAS

This chapter describes state and national programs to fight teen pregnancy. Names and addresses of programs are provided for those who might want to consider replicating ideas.

Chapter VIII: WHAT STATES ARE DOING

This chapter summarizes initiatives proposed and taken by individual states to solve the problem of teenage pregnancy. It is up to date to mid-1989.

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INTRODUCTION

The sun is setting on an April evening in Juneau, 1989. A boy and a girl wait at a bus stop outside the hospital, smoking cigarettes. Her hospital gown balloons over her pregnancy. The bus pulls into sight over the crest of the hill. They kiss. She turns back to the hospital, he stubs out his cigarette, digs into his pocket for quarters, enters the bus. "It must be hard taking the bus to see her," says a passenger as the boy sits down. He nods. "But things will get easier next week -- I turn 16 and can get my driver's license."

A Soldotna girl about to become an unwed mother at the age of 15 wrote a letter to her local newspaper last May. Barbi Miller said she wanted to warn her friends to think ahead and learn from her mistake. "It really isn't right," she wrote, "to go from age 15 to 20 in a matter of months." Statistics show how valid her observation is. Parenting too soon can rob a teenager and her child; it will cripple some for a lifetime. Teen parents find it harder to finish school, harder to earn a decent living, harder to care for their children. Half the U.S. teens who have babies never get a high school diploma (Hayes and Hofferth, p. 288). Almost one in three will have a second baby within two years of the first (Henshaw et al, p. 59). Many will be poor. One third will turn to welfare (Burt and Haffner, p. 5). Their children are at increased risk to be abused, neglected and hospitalized (Comfort, p. 955). They score lower on developmental and cognitive tests and they risk becoming young parents themselves (Moore and Burt, p. 33).

On an average day in Alaska, between six and seven teenagers become pregnant. Three a day give birth. Most will keep and raise their children. These very young mothers have a lifelong commitment that threatens to stunt their lives and those of their offspring. Still children themselves, many face a daunting future of poverty and dependency. By the most conservative estimate, the public will pay $51.4 million a year to support the needy families of Alaska mothers who had their first babies when they were teenagers. Babies born to teen mothers in one year will cost the public $21.5 million by the time they reach adulthood (in today's dollars). The public pays about $4 million every year to support needy families of Alaska mothers who are still not yet 20 years old. It pays more than $12,000 a year to support one needy teen mother and her children.

These are basic public assistance costs of teen <u>births</u>: Aid to Families for Dependent Children, Medicaid and Food Stamps only. Estimates do not include any other public services needed by young mothers and their children such as remedial and special education, housing, child protection services, counseling, foster care, child care and job training. In addition, this report does not reflect the personal and public costs of teen <u>pregnancy</u>. Experts believe more than 2,400 Alaska teenagers became pregnant in 1985 while about 1,100 gave birth (Henshaw and Van Vort, p. 87). More than half of all teen pregnancies that year ended in abortion or miscarriage and neither these costs nor the costs of intervening to prevent future pregnancies figure into the costs of this report.

> "It isn't as easy as it may seem. In fact, it's really not right to miss your most carefree years and go from the age of 15 to 20 in a matter of months."
>
> -- Barbi Miller, 15, pregnant
> Soldotna

This paper shows the extent, the causes and the consequences of untimely pregnancy and parenthood. It presents options other entities have used to deal with what most authorities label a grave and growing social problem. So personal, sensitive and immediate a topic generates diverse opinions on how to solve it. The range of these sometimes disparate proposals is presented for discussion.

DEFINITIONS

Birth Rate. Live births per 1,000 women in a specified age group.
Infant Mortality Rate. The number of deaths to infants born to mothers in a specified age group, divided by the total live births to these mothers multiplied by 1,000.

Low Birthweight. A baby whose birthweight is less than 2,500 grams (approximately 5 lb. 8 oz.). 100 grams = 3.5 ounces.

Sexually Active. This refers to anyone who has ever had sexual intercourse. It does not imply frequency of intercourse.

Teen Birth Rate and Teen Pregnancy Rate. These are not synonymous. Alaska can identify birth rates, but it cannot identify pregnancy rates because the state keeps no record of pregnancies terminated by abortion, stillbirth or miscarriage.

Chapter I

ALASKA PORTRAIT: SOMEONE'S DAUGHTER

Teen parenting is more than a distant symbol of hopelessness in an East St. Louis slum filling the television screen between advertisements on 60 Minutes. A 15-year-old mother lives anywhere in Alaska. She is someone's daughter, impregnated by someone's son. She is urban or rural, poor or middle-class. She can be your neighbor, your child, your grandchild. Her problems and those of her children cost Alaska money and resources.

You will read in this report that between six and seven Alaska teenagers a day become pregnant and three a day have babies. That two a day are 18 or 19 years old. That one a day is high school age -- between 15 and 17 years old. That every other day the older teen mother is having a second, third or even fourth baby. That once a month the very young mother is also having a second, third or fourth baby. That once every 33 days the new mother is 14 years old or younger. That 96 percent of unmarried teen mothers keep and raise their children. But statistics are only numbers. For the immediate, personal impact of precipitate pregnancy and parenting, we turn to anecdote. Consider these true stories, collected at random during the Spring and Summer of 1989:[1]

---

[1] Sources are Rose Waite, public health nurse, Anchorage; Joyce Murphy, President, Board of Directors, Booth Memorial Home; Donna Teekell, Program Director, Booth Memorial Home; Jeanette Rodgers, nurse, Kenai Central High School and Jenny Jolly, whose interviews with pregnant and parenting teens were published in the May issue of the Kenai Central High School Scarlet Letter. To protect a teen's anonymity, sources are not identified for individual cases.

A 13-year-old Alaska girl was pregnant in late 1988 with her second child. Both babies were fathered by her own father.

- A 16 year old part-time aide in an Anchorage animal clinic is pregnant with her fourth child by different fathers. Abused, she abuses her own children.

- A small town high school student -- described by a nurse as "bright, popular, motivated" -- goes to a doctor as soon as she discovers she is pregnant. She eats carefully, takes vitamins, lives at home and will keep her baby.

- A 13-year-old Alaska girl is pregnant in late 1988 with her second child. Both babies were fathered by her own father.

- After a long delivery, a college-bound Alaska senior who had decided on adoption, holds her newborn baby contrary to the advice of nurses. "I marveled at my little girl," she tells another student. "She had blue eyes, just like mine... I told her how precious she was and how much her Mommy and Daddy were going to love her... Then I said goodbye and let her go."

- An Anchorage teen, entranced with a friend's "cute" baby, goes to a clinic asking how to get pregnant. "Have you thought about the problems you'll face and how expensive it will be?" the nurse asks. "Yes, but I've got it worked out. I'm going to apply for Medicaid."

> "I told her how precious she was...Then I said goodbye and let her go."
>
> -- Kenai Peninsula senior who put her baby up for adoption

- An Anchorage 17-year-old sits in a municipal family planning clinic, her baby in her arms, waiting for the results of a pregnancy test. When she learns it is positive, she tells the nurse, "I was going to get around to it (birth control), but I just didn't think..."

- Drug abusing pregnant Alaska teens -- some addicts since they were toddlers, some first exposed to drugs in the womb, some fed drugs and alcohol by parents who wanted peace and quiet -- give birth to addicted babies so difficult to care for that they are at risk for child abuse.

- Barbi Miller of Soldotna, 15 and pregnant, writes to the Peninsula Clarion in May 1989:

  "(Teen pregnancy) is not as easy as it may seem. In fact, it's really not right to miss your most carefree years and go from the age of 15 to 20 in a matter of months. I've learned from my mistake... I would like to encourage other young teens to think ahead." The letter describes a survey of 70 school friends in which the "vast majority" asked for sex education classes and easier access to birth control. On the newspaper's front page is a report that an approved school health curriculum had fallen into "limbo" the night before when a school board member asked to reconsider his vote (May 3, 1989).

- A self-described "shy and quiet" high school student with good grades, "too intelligent and together" to be in "this predicament", has an abortion alone because she is afraid to tell her parents. She later tells a friend the doctor and nurse asked the mandatory questions, never "really looked" her in the eye, gave her a Walkman with dead batteries to wear during the "very, very scary procedure" and left the room afterward without saying anything to her. Her parents are still unaware. She has "asked for forgiveness and made peace" about the abortion but still finds it hard to talk about it.

- A young woman on her way to college with "high hopes and ambitions" and parents she describes as well educated and "two of my best friends" was so drunk the night she conceived that she didn't care who she was having sex with. "The world seemed warm and fuzzy, and I thought it was neat this guy liked me," she says. After considering suicide, she chose to have the baby, and on the delivery table saw her childhood "slip away with every push." "I love my little boy with all my heart," she says, but being a mother is "not like playing house." College is out because she can't afford it. "Plus, where would I ever find the time?"

CAUTION

Although on quick review, many people confuse <u>birth rate</u> with <u>pregnancy rate</u>, the terms are not synonyms. Pregnancy rate includes induced and spontaneous abortions as well as births.

Chapter II

THREE A DAY: TEEN BIRTHS IN ALASKA

One in eight Alaska teenage women over age 14 becomes pregnant. One in 17 has a baby. Three Alaska teenagers a day give birth. Of these, two are 18 or 19 years old and one is school age -- between 15 and 17 years old. Every other day, the older teen is having a second, third or even fourth baby. Every two weeks, the very young teen is also having a second, third or even fourth baby. Once a month, the new mother is 14 or younger. Most teen mothers keep their babies. As many as three in five of the fathers may be adolescents.

Alaska has the second highest teen pregnancy rate among the 50 states, according to researchers from the Alan Guttmacher Institute (Henshaw et al, pp. 27 and 34). Despite this alarming reported ranking, this report concentrates on teens births, not on pregnancies, because Alaska keeps no record of induced or spontaneous abortions and, therefore, no accurate record of the number of pregnancies.

By disregarding teen pregnancies and concentrating only on teens who bear and raise children, we ignore significant costs. One is the cost of intervention. Like the Anchorage girl who had "four or five" miscarriages and abortions by the time she was 14, many teenagers need intervention to get out of the sometimes unhealthy and incestuous cycles which created their early pregnancies in the first place. Teen pregnancy experts believe pregnant teens can cost the public money, whether they have an abortion, give the baby up for adoption, or raise the child. "They'll get AIDS, or a venereal disease, or be into drugs and alcohol, or have a damaged child and in one or all of these ways be a

serious cost and detriment to productive society," says Joyce Murphy, a director of the Booth Memorial Home, Alaska's only residential home for homeless pregnant teens.

This chapter contains data on the rate and number of teen births in Alaska, using statistics provided by the state Department of Health and Social Services Vital Statistics Research. These numbers are compared with statistics from the U.S. and from other nations. For national trends in adolescent sexual activity, pregnancies, births and abortions see pp. 101 to 106 of this report.

A) Rate of Alaska Teen Births

1. Comparing Alaska's rates to U.S. and world rates.

Alaska's adolescent birth rate in 1985 ranked higher than that of 41 other states (Henshaw et al, p. 27). It is far higher than rates in most of the world's developed -- and many undeveloped -- nations (see Figure 1). This means that while Alaska teenagers are having and caring for babies, teenagers in other states and other countries are going to school and learning the work and life skills needed to become self sufficient adults.

The statistics for 1987 follow (the last year for which data are available). "Teenager" refers to young women ages 15-19:[2]

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[2] Sources: U.S. rates from S. Henshaw and J. Van Vort: "Teenage Abortion, Birth and Pregnancy Statistics: An Update", Family Planning Perspectives, March-April 1989 and "Monthly Vital Statistics Report", June 29, 1989, National Center for Health Statistics; Alaska rates calculated from birth data provided by Alaska Department of Health and Social Services Vital Statistics Research and population data provided by Alaska Department of Labor Research and Analysis; international rates from United Nations Demographic Yearbook 1986, New York, New York.

* Nationwide, among every one thousand 15-19 year old females, there were 51 births. In Alaska, meanwhile, there were 60 births among every one thousand teen females. (Among an estimated 18,041 females age 15-19 years old, there were 1,087 births.) This rate may be conservative: national experts report the state's adolesent birth rate at 66 per one thousand teenage females (Henshaw et al, p. 27).

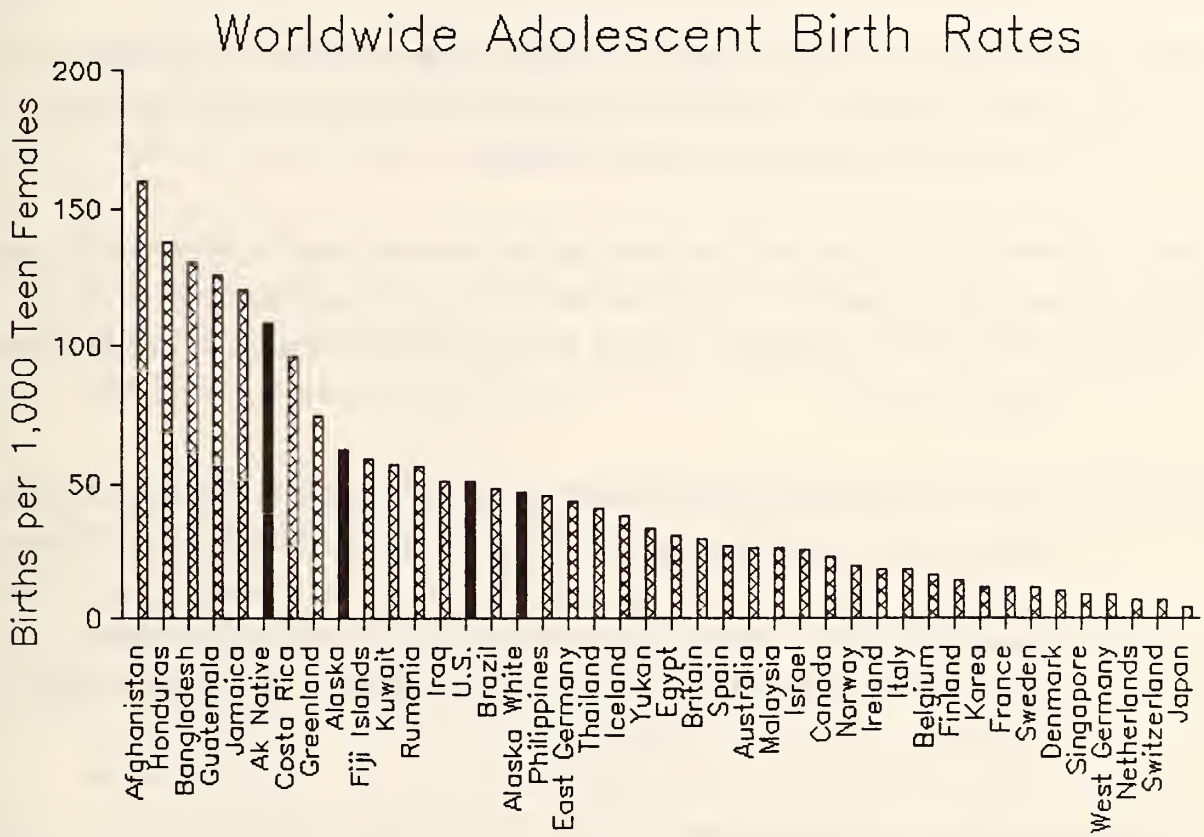
* Preliminary state Department of Labor demography estimates place the Alaska Native adolescent birth rate at 110.5 births per one thousand females 15-19 years old (Williams, ASFR 15-19). This is four fifths again as high as the statewide rate. The estimate may be conservative: using slightly different population data, the Alaska Area Native Health Service estimates the 1984-86 rate at 115 (Boedeker, p. 1). In the interests of consistency, estimates based on state demography and vital statistics data are used in this report.

* Alaska's White teen birth rate is preliminarily estimated at 47.2 births per one thousand (Williams, ASFR 15-19). This is higher than total birth rates in Canada, Ireland and Japan <u>combined</u>. It is nearly as high as the U.S. rate for all races, which includes the Black rate.

* The Alaska Native teen birth rate was more than twice Alaska's White teen birth rate. It exceeded the troubling U.S. Black rate (100 births per thousand). Alaska's Native teen <u>birth</u> rate was on a par with the nation's 1985 teen <u>pregnancy</u> rate of 110 pregnancies per one thousand teen females.

* The United Nations lists only ten countries with rates higher than the Alaska Native teen birth rate. They are Afghanistan, Honduras, Bangladesh, Guatemala, Malawi, Belize, Montserrat, Saint Lucia, Saint Vincent and Jamaica.

Figure 1



Sources: Alaska Department of Labor; National Center for Health Statistics; Demographic Yearbook 1986, United Nations; Canadian Office of Vital Statistics.

> "Teen pregnancy is the single most important birth control issue in the United States."
>
> -- Carl Djerassi
> Co-discoverer of the birth control pill

* Alaska's teen birth rate was 81% percent higher than that of the state's nearest neighbor, the Yukon Territory, where there were 33 births per one thousand teen females.

* Our rate is far greater than that of nations similarly situated above the 60th Parallel: 38 births per one thousand teen females in Iceland, 19 in Norway, 14 in Finland, 11 in Sweden. (Greenland is higher at 75.)

* Sixty developed and undeveloped countries listed in the United Nations Demographic Yearbook 1986 have teen birth rates lower than Alaska's. An Alaska teen's chance of having a baby is almost three times a Canadian teen's. It is 15 times a Japanese teen's. A teen has less chance of giving birth in Iraq, Egypt, Brazil, Thailand, Kuwait and Rumania than she does in Alaska.

Although Alaska's Native teen birth rate is more than double the state's White teen birth rate, it would be erroneous to assume that Native teens are more than twice as likely as White teens to become pregnant. State pregnancy experts believe Alaska Native teens are less likely than their White peers to obtain abortions (Scales, pers. comm., 1989).

Figure 1 on the preceding page compares Alaska's state and Native teen birth rates with the rates of selected countries. Table 1a in Appendix I compares U.S. and Alaska numerical rates with nations around the world.

2. Trends in Alaska and U.S. teen birth rates.[3]

Birth rates among Alaska and U.S. teens have fallen since 1970. Meanwhile, rates have risen among Alaska Native teens. The statistics for teens ages 15 to 19:

* In 1970, for every one thousand U.S. teen females, 68 gave birth. The rate fell in the 1970's and has remained at about 51 births per one thousand teen females since 1983 (it was 51.1 in 1987).

* Nationwide, Blacks have a higher teen birth rate than other races, but even among this group, the rate dropped. In 1970, 141 of every one thousand Black teen females had a baby. By 1987 there were 100 births per thousand Black teen females.

* In Alaska, births per one thousand teen females of all races dropped from 94 births in 1970 to 60 births in 1987.

* Among Alaska Whites, births per one thousand teen females dropped from 89 births in 1970 to 47 births in 1987 (Williams, ASFR 15-19).

* Meanwhile, the rate rose among the subgroup of Alaska Natives. Births for every one thousand Alaska Native teen females rose from 99 births in 1970 to 110.5 births in 1987.[4]

In summary, while the Alaska Native teen birth rate increased in 17 years, the rates decreased among U.S. and other Alaska teens (1980-86 are illustrated in Figure 2). Table 2a in Appendix I shows birth rates in selected years.

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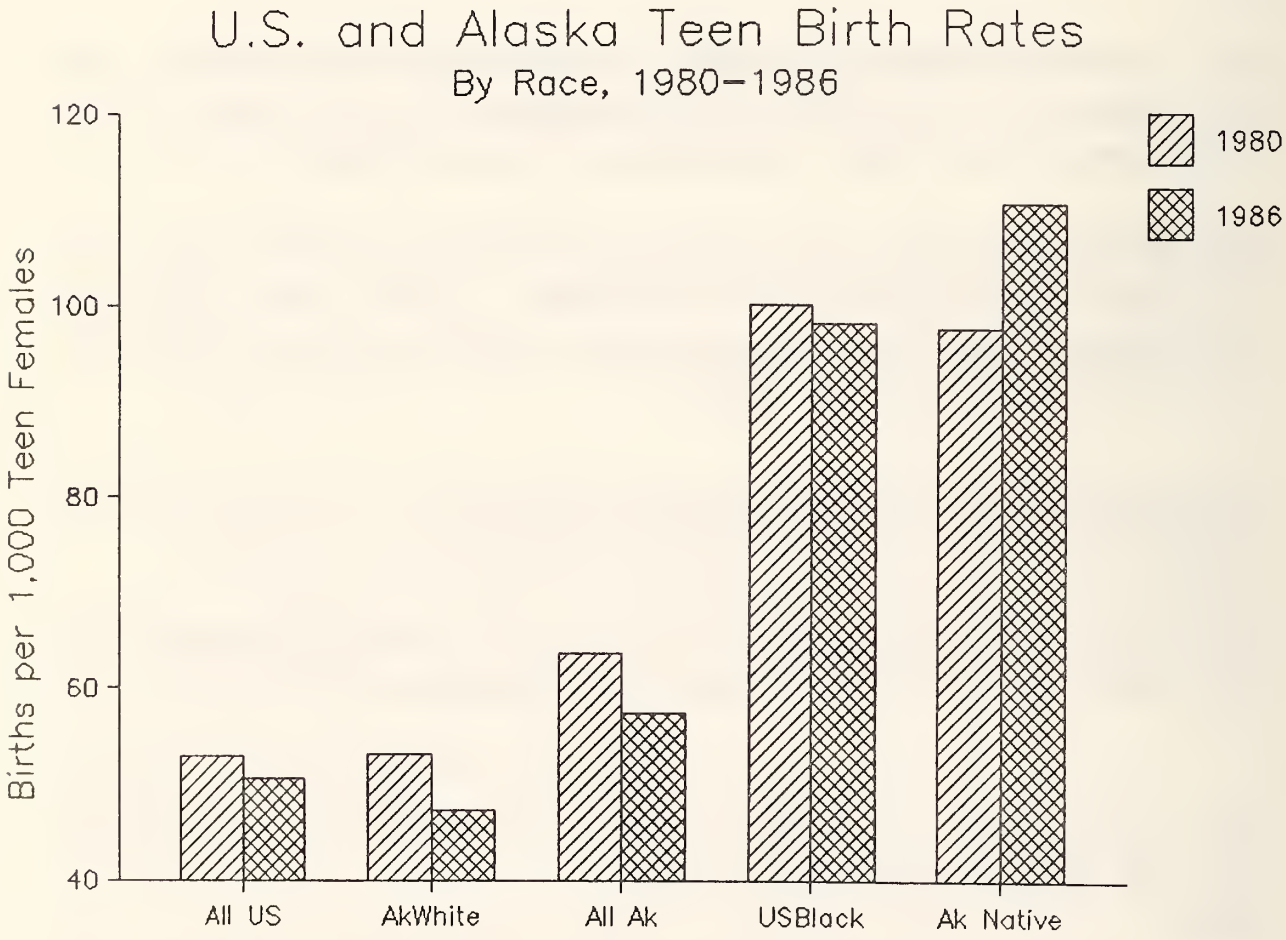
[3] See Footnote 2 for sources.

[4] The Alaska Area Native Health Service estimates the 1984-86 Native teen birth rate at 115.2, on a three-year average (Boedeker, 1989).

Figure 2



Sources: Alaska births: Vital Statistics Research, Alaska Department of Health and Social Services, June 5, 1989; population and birth rate estimates: Division of Research and Analysis, Alaska Department of Labor; U.S. birth rates, Monthly Vital Statistics Report, National Center for Health Statistics, July 12, 1988.

3. Trends in Alaska teen birth rates by age

The decline in Alaska's state teen birth rate in the 1980's appears to have been among older, not younger, adolescents. It is younger teens, however, who are less likely to have finished school, less likely to have job skills and, therefore, more likely to remain dependent. Birth rates for Alaska teens between 15 and 19 in the years 1982 and 1987:

* For every one thousand Alaska 15-19 year old females, 68.5 gave birth in 1982. In 1987, the rate was 60 births per thousand teens.

* The largest drop in births per thousand females was among those age 18-19 years old. The rate in 1982 was 117 births per thousand, compared to a 1987 rate of 106 births per thousand.

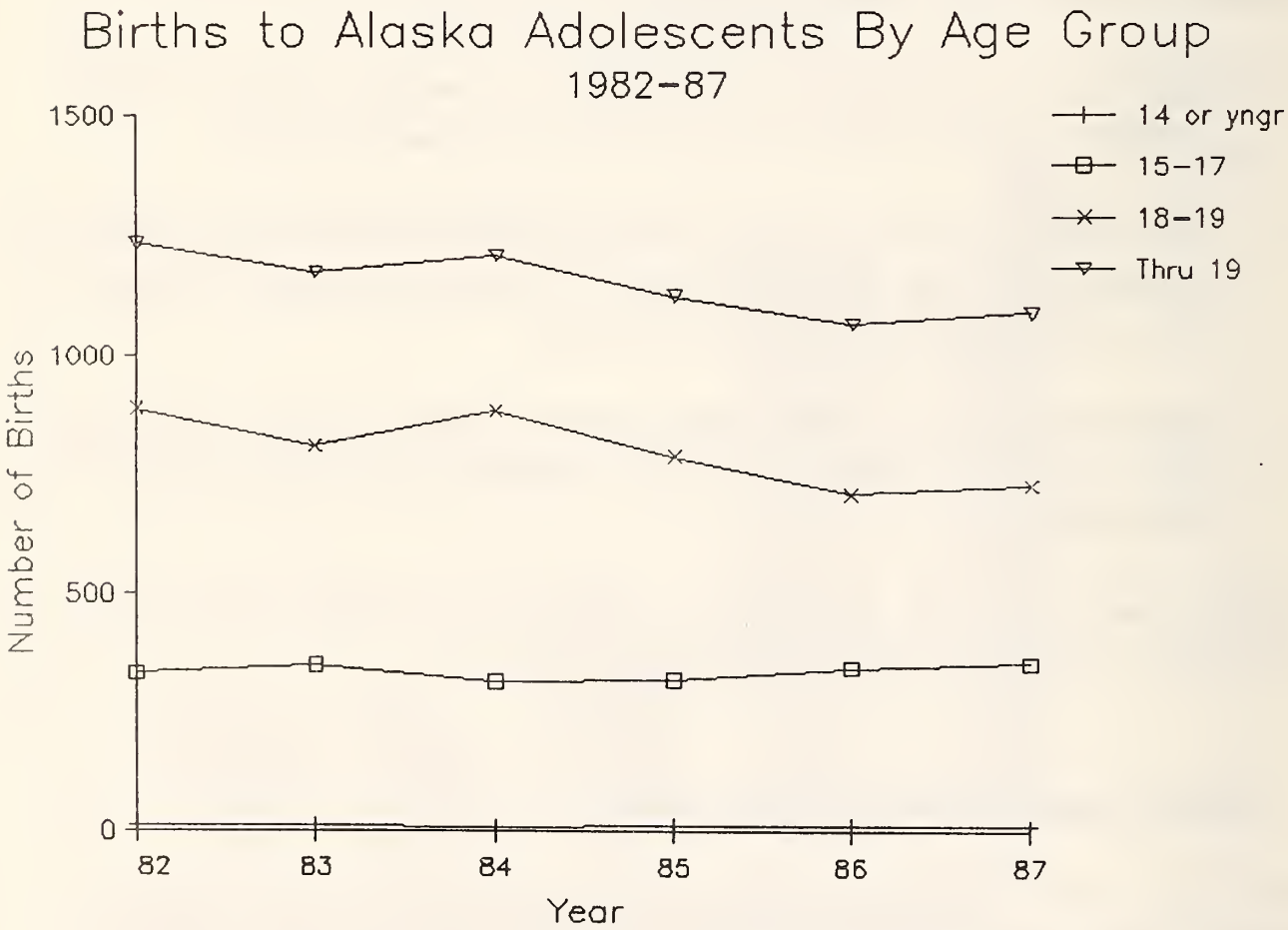
* But births per one thousand females age 15-17 years old fell hardly at all. The rate in 1982 was 32 births, compared to the rate in 1987 of 31 births.

Alaska's teen birth rates by age group between 1982 and 1987 (computed on a three-year average) are found in Appendix I, Table 3a.

4. Rate of second, third and fourth births.

About one in five Alaska teens who give birth are having a second, third or fourth child. This may be slightly lower than the U.S. rate. In 1985, 23 percent of U.S. teens who gave birth had already had a child, while in Alaska the portion was 21 percent (Silverman, pers., comm., 1989; Pittman 1988, p. 10).

Figure 3



Source: Vital Statistics Research Division, Alaska Department of Health and Social Services, March 21, 1989.

B) Number of Adolescent Births in Alaska

Although on quick reading, it is possible to confuse rate and number, the two terms are not synonyms. Rate tells what portion of teen females give birth; number ignores the portion and simply tells how many teens are pregnant.

The actual number of births to Alaska adolescents fell between 1982 and 1987 (while the population of Alaska teenage girls increased less than one percent). In 1982, 1,235 adolescents of all ages gave birth. By 1987, the number had fallen to 1,087 births (Vital Statistics, June 5, 1989).

The top line of Figure 3 graphs the all-age-group decrease in number. Table 4a in Appendix I shows the numbers by year.

1. Average number of births to Alaska teens.

Based on births over six years, an average of 1,150 Alaska adolescents give birth a year (about three a day). On an average:[5]

* Among Alaska girls 14 and younger, 11 give birth every year (one every 33 days).

* Among Alaska teens 15-17 years of age, 334 give birth every year (almost one a day).

* Among Alaska teens 18-19 years of age, 800 give birth every year (about two a day).

[5] Based on actual births in each age group between 1982-87.

Table 1

Children of Mothers Who Are 19 or Younger in 1989
Alaska (a)

	1984	1985	1986	1987	1988 (b)	1989 (b)
Births Ea. Year Of Children Whose Mothers Remain Teens in 1989	10	119	254	364	727	1077
Child Turns This Age in 1989	5	4	3	2	1	Baby
Mother was This Age or Less on Day Baby Was Born	14	15	16	17	18	19

Source: Vital Statistics Research Division, Alaska Department of Health and Social Services.

(a) Note that mother's age at delivery but child's age in 1989 are shown. Also, mothers who had babies as teens but are now in their 20's have "graduated" from this list and are not counted.

(b) Data for 1988 and 1989 are provisional.

The United Nations lists only ten nations with teen birth rates higher than that of Alaska Natives.

2. Number of births to Alaska mothers who are still teens

About 2,550 children were born in Alaska during the last six years to mothers who are not yet 20 years old today. Ten of the children will turn six in 1990; their mothers were 14 or even younger when the children were born.

There are about 2,200 young women currently in their teens who have given birth in Alaska (Silverman, pers. comm., 1989). About 330 have given birth more than once. The number of children, their ages and the ages of their mothers when the child was born are shown on Table 1 on page 18. Reading down the columns:

* Ten children who turn five this year were born in 1984 to mothers who were 14 or younger (column one).

* 119 children who turn four this year were born in 1985 to mothers who were 15 or younger (column two).

* 254 children who turn three this year were born in 1986 to mothers who were age 16 or younger (column three).

* 364 children who turn two this year were born in 1987 to mothers who were age 17 or younger (column four).

* 727 children who turn one this year were born in 1988 to mothers who were age 18 or younger (column five).

* By the end of 1989, an estimated 1,077 babies will have been born to mothers who are age 19 or younger.

About 2,550 Alaska children have mothers who are not yet 20 years old. The oldest child will start school next year.

These are the babies born in Alaska to mothers who are still in their teens. How many still live in the state today? How many live with their mothers? State statistics provide no ready answers. No state data show how many children and their teenage mothers may have moved away, how many are being raised by their grandparents and how many were given up for adoption. Teen pregnancy experts believe the last number is probably small: nationally, only four percent of unmarried teens put their children into adoption (Guttmacher Institute, pers. comm., 1989).[6]

[6] Adolescent pregnancy expert Peter Scales of Anchorage states that this national trend away from adoption has been consistent for more than a decade and probably holds true in Alaska as well. He characterizes as a "small anomaly" the fact that all five pregnant teens who lived at the Anchorage-based Booth Home between July 1988 and April 1989 placed their infants in adoption (pers. comm., 1989). Program Director Donna Teekell says the home has not changed how it counsels pregnant teens (pers. comm., 1989).

C) Geographical Distribution of Alaska Adolescent Births

The probability that an Alaska teenager will give birth varies according to where she lives in the state. For example, between 1985 and 1987, an average of one in eight teen women ages 15 to 19 in the Northwest Arctic and North Slope census areas gave birth. In the Nome, Wade Hampton and Dillingham areas, one in nine gave birth. Meanwhile, in the Wrangell-Petersburg area, one teen woman in 27 gave birth and in the Bristol Bay census area, one in 65 had babies.

Figure 4 is a graph of Alaska teen birth rates by census area for the years 1985-87. See Table 5a in Appendix I for a list of specific rates by area for the years 1985-87. Rates are averaged over three years.

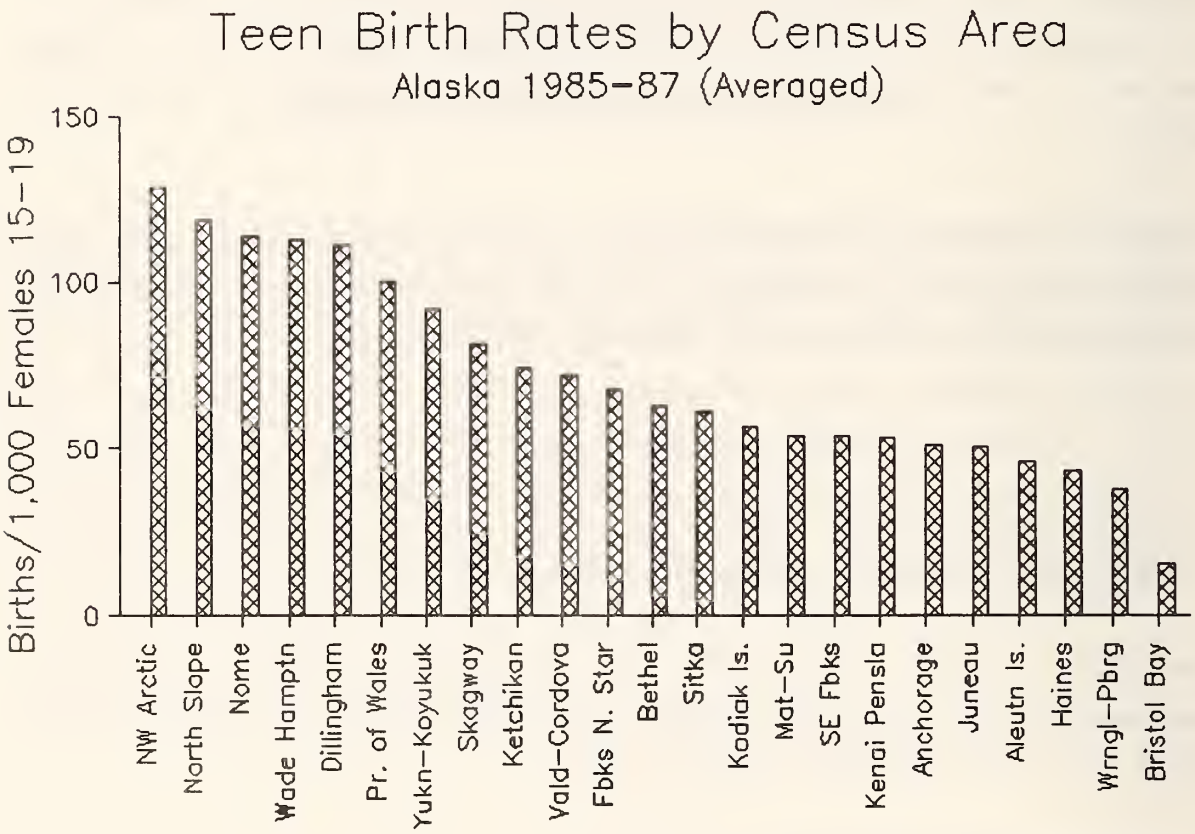
D) Marriages Among Alaska Adolescent Mothers

Between 1985 and 1987, nearly three fifths (58 percent) of Alaska teen mothers were unmarried when they gave birth. This includes half the 18-19 year old mothers, typically the most likely to marry.

1. Geographical distribution.

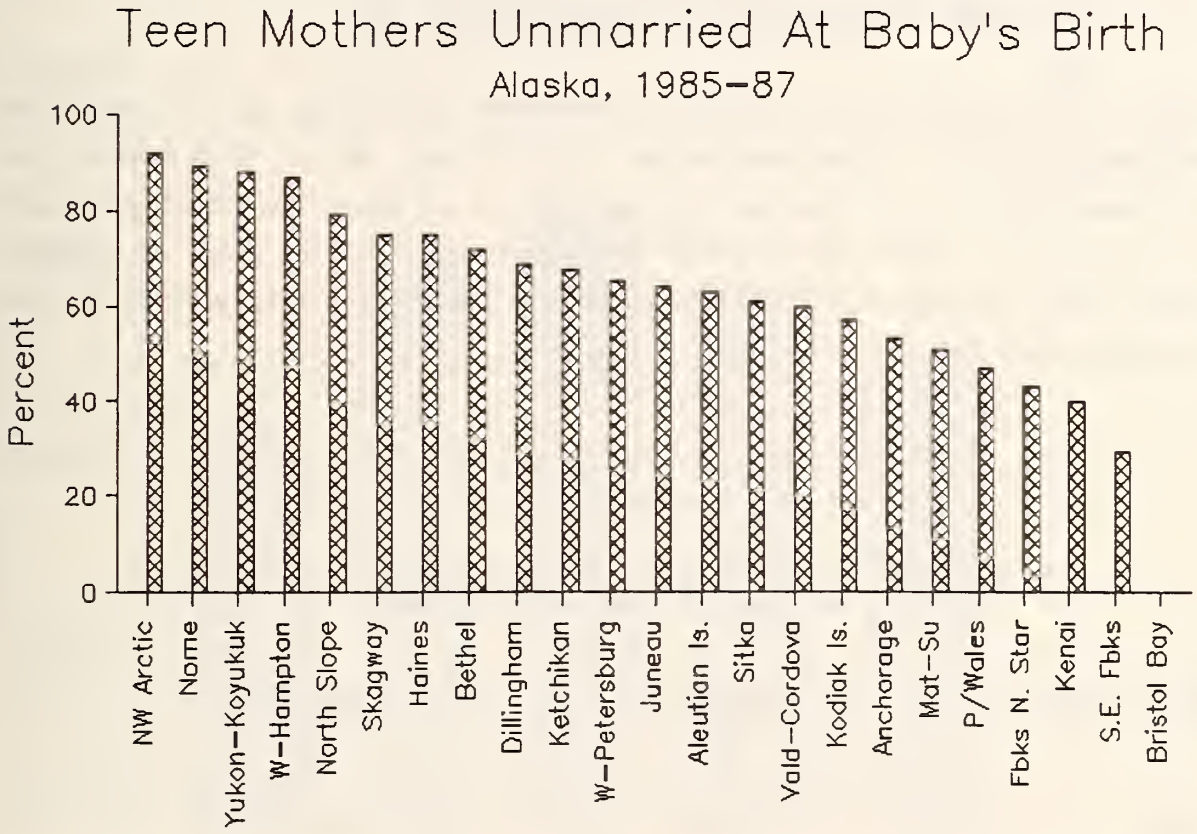
The probability of being married at the time of delivery varies by geographical location. In some areas of Alaska, almost all teen mothers are unmarried when their baby is born. For example, in 1985-87, nearly nine out of ten teens who gave birth in the Northwest Arctic, Nome, Yukon-Koyukuk and Wade Hampton areas were single when the baby was born. Figure 5 is a graph of the portion of teens by area who gave birth as single parents between 1985-87. Table 6a in Appendix I shows specific percentages. Numbers are averaged over three years.

Figure 4



Source: Alaska Departments of Health and Social Services and Labor.

Figure 5



Source: Vital Statistics Research Division, Alaska Department of Health and Social Services.

2. The trend nationwide.

Increasingly nationwide, teen mothers are unmarried when the baby is born. Although total teen birth rates are declining, the rate of births to unmarried teen mothers is rising. For example, in 1970, about 30 percent of all U.S. teen births were to mothers unmarried at the time of delivery. By 1985, the portion had jumped to 59 percent (Pittman 1988, p. 11).

Figure 6 illustrates the increasing phenomenon of births to U.S. unmarried adolescent mothers. Note how the top stack of each bar -- teen mothers who were unmarried at the time the baby was born -- grows significantly between 1960 and 1980. Table 2 is a moment in time in the U.S. It shows at a glance that in 1983, younger U.S. teen new mothers are much less likely to be married than older new mothers.

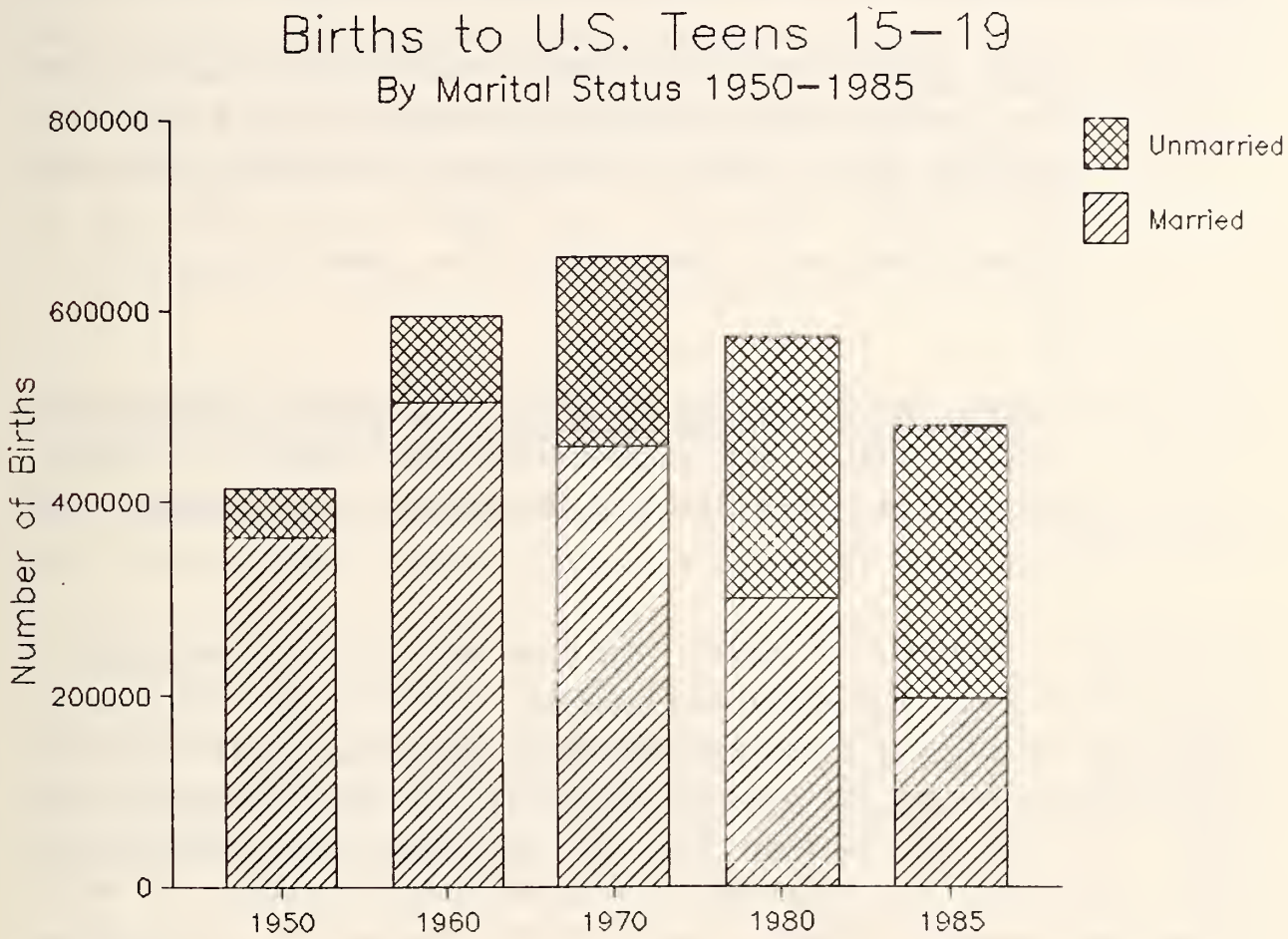
Table 2

U.S. Mothers Younger than 20, Percent Married and Unmarried
At Time of Baby's Birth, 1983

Age of Mother	Married (%)	Unmarried (%)
Total	45.9	54.1
Under 15	9.6	90.1
15-17	32.5	67.5
18-19	54.3	45.7

Source: Adapted from Karen Pittman, Advocate's Guide to the Numbers, Children's Defense Fund, Washington, D.C., 1988, using unpublished data from the National Center for Health Statistics.

Figure 6



Source: Adapted from Karen Pittman, Advocate's Guide to the Numbers, Children's Defense Fund, Washington, D.C., 1988, using unpublished data from the National Center for Health Statistics.

3. Economic difficulties of married teen couples

Being married doesn't necessarily improve life for a teen mother. It can, in fact, make it worse because both husband and wife are likely to be young. There are two reasons why youth works against these couples.

* First, teens who marry either before or after the birth of a child have a greater chance of an unstable marriage and the accompanying problems, such as divorce, child abuse, child neglect (Moore and Burt, p. 21). Almost one in four women who marry before age 18 separate from their husbands within five years (Pittman 1983, p. 5).

* Second, even if both spouses work, their combined wages may not support a family. U.S. young married couple families are twice as likely to be poor now than just 16 years ago (Johnson et al, p. 8).

The Children's Defense Fund[7] reports that young men today, with or without a high school diploma, have diminished prospects. They are more likely to be unemployed, sporadically employed or employed at low wages. The wife can work, while paying child care, but wages for females are traditionally lower than for males. In 1986, one in eight young married couples with children were poor. At the same time, 40 percent of young men between the ages of 20 and 29 did not earn enough to support a family of three (Johnson et al, pp. 23 and 48).

[7] Statistics in this section are from Clifford M. Johnson, Andrew M. Sum and James Weill: Vanishing Dreams: The Growing Economic Plight of America's Young Families, The Children's Defense Fund and Center for Labor Market Studies, Northeastern University, Washington, D.C., 1988.

Researchers believe that nationally, this phenomenon is contributing to the increase in never-married teen mothers. In the past, community pressure or economics pushed young parents into marrying before the birth of a baby. Today, with the reduced earning power of young men and the fragility of teen marriages, marriage is less sure to bring security. A young man who earns enough money to support a family above the federal poverty level is three to four times more likely to be married than his peer with below poverty earnings. From 1973 to 1986, the group of young men below poverty grew by one third while marriage rates among all young men fell by one third (Johnson et al, p. 6).

E) A Statistical Snapshot of Alaska Adolescents Who Give Birth

This section examines characteristics of teen mothers and their babies in one year: 1987 (the latest year statistics are available). That year:[8]

1. How many?

Six percent of Alaska teenage women had babies -- one in every 17 teen women. Teens accounted for one in every 11 babies born in the state. In 1987, a total of 1,087 Alaska teens gave birth.

2. How old?

Two thirds of Alaska teen mothers were 18 and 19 years old. Nearly one third were 15 to 17 years old. In 1987, 724 new mothers were 18 and 19 years old and

[8] Data for 1987 provided by Division of Vital Statistics, Alaska Department of Health and Social Services; data for 1985 are from Family Planning Advisory Committee, Municipality of Anchorage.

351 mothers were 15 to 17 years old. Ten were age 14 or younger. The ages of two were unknown.

3. Married or single?

About three fifths (60 percent) of Alaska teen mothers were unmarried when their baby was born. In 1987, 663 teen mothers were unmarried when the baby was born.

4. How many children?

Nearly one fifth of Alaska teens giving birth had already had at least one baby. Most were 18-19 years old, but 30 mothers were 15-17 years old. That year, no girl under 15 gave birth. In 1987, 198 teens who gave birth had already had at least one baby. Of these, 167 mothers were 18-19 years old.

5. How healthy are the babies?

In 1987, nine babies of Alaska teen mothers died before their first birthday (Silverman, pers. comm., 1989). In Alaska, as in the nation, babies born to teen mothers appear more likely than babies of older mothers to die before their first birthday. Over a period of five years (1982-1987), the infant mortality rate in Alaska was 15 infant deaths per one thousand live births among teens versus nine infant deaths per one thousand live births among older women (Silverman, pers. comm., 1989).

In 1985, one in every 15 births to Alaska teens (6.6 percent) was low birthweight compared to one in every 20 births (4.9 percent) among Alaska women of all ages. Comparable 1987 numbers in the U.S. are 9.3 percent for babies born to 15-19 year olds and 6.9 percent for babies born to all mothers (National Center for Health Statistics, June 29, 1989). Babies born too small are at risk for lifelong physical and mental disabilities.

F) The Male Partner

Until recently, the "putative" father has been all but ignored by analysts and policy makers, who have seen teen pregnancy as a problem for the teenage girl, her child and perhaps her parents. Yet by their 18th birthday, U.S. boys are nearly half again as likely as U.S. girls to be sexually active -- 67 percent of boys v. 44 percent of girls (Hayes, p. 97). As governments begin to assess financial responsibility and fathers to assert their paternal rights, researchers are looking more closely at the young, unwed father.

1. Information is sparse

Little is known about young, unwed fathers. Women are not required to supply information about the father of their child on birth certificates. Two thirds of unmarried teenage mothers provide none, leaving large gaps in data (Pittman 1988, p. 33). Alaska, for example, collects no demographic information about the male partner in a teen pregnancy (Williams, pers. comm., 1989). National statistics are unreliable, and studies cannot be applied generally.

By their 18th birthday, U.S. boys are 45 percent more likely than U.S. girls to be sexually active.

2. Age of the father.

Even the age of the young unwed father is difficult to determine. Anecdote illustrates that the father can be almost any age: one 13-year-old homeless girl in Alaska carried to term a baby whose father was a 10-year-old boy (Murphy, pers., comm., 1989). Alaska pregnancy expert Peter Scales' rule of

thumb is that putative fathers in teen pregnancies are about three years older than the mothers (pers. comm., 1989). Using available statistics, two research groups recently attempted a systematic estimate. The results, summarized below, support Scales' rule. Both groups emphasize that information is incomplete in 36-38 percent of teen births (Smollar and Ooms, p. 24; Pittman 1988, p. 33).

* The Young Unwed Fathers Project, funded by the U.S. Department of Health and Human Services, uses National for Health Statistics published data for 1985. It suggests that at least half of the fathers in teen pregnancies are in their teens or early 20's.

  Among teen mothers who reported the age of their partner, 18 percent said the father was under age 20, and 35 percent said he was between 20 and 24 years (Smollar and Ooms, p. 24).. The actual portion of younger fathers may be much larger. Nearly two fifths of teen mothers, most of them unmarried, do not report the father's age. Unmarried teen mothers tend to be younger than married teen mothers.

* The Children's Defense Fund, using unpublished National Center for Health Statistics data for 1983, divides statistics between married and unmarried teen mothers. The data show that most fathers in adolescent pregnancies are in their teens or early 20's.

  Unmarried: Among unmarried teen mothers -- and the majority of these mothers are unmarried -- who reported, 42.7 percent said the father was under age 20 and 44.3 percent said he was between 20 and 24 years (Pittman 1988, p. 30).

  Younger unmarried mothers are more likely to have younger partners. For example, among mothers who reported in 1983, 96 percent of mothers under 15 and 93 percent of mothers age 15-17 said their partners were under 25.

Among 18-19 year old mothers, 82 percent said the father was under 25 (Pittman 1988, pp. 30-1).

Married: When the teen mother was married, among those who reported (and the great majority did), 24.5 percent said the father was under age 20 and 60 percent said he was between 20 and 24 years (Pittman 1988, p. 30).

Table 3 shows in more detail the reported age of the putative fathers in U.S. adolescent pregnancies in 1983. (Those interested in statistics by age group may turn to Table 7a in Appendix I.) Table 3 is most easily read by column:

* The first column tells the male partner's age when the teen mother was married (46 percent of the mothers were married that year). Because most married mothers reported the age of the father, this column is almost complete (only 0.5 percent "not stated"). It shows that the large majority of the fathers when the teen mother was married were young: 84 percent were under 25.

* The second column tells the male partner's age when the teen mother was not married (54 percent of the mothers were not married that year). Information for this group is very incomplete. The last entry in this column shows that 65.7 percent of these mothers did not give information on the child's father. Among all unmarried teen mothers, 30 percent said the father was under 25. (The actual portion is probably larger, however, because so many unmarried mothers do not report.)

* The third column is an "enlargement" of Column 2. It shows that among the one third of unmarried mothers who reported (that is, the numbers in Column 2 above "65.7"), 87 percent said the child's father was under age 25.

Table 3

U.S. Mothers Younger than 20 and the Reported Age of the Fathers Of Their Children, 1983 (a)

Age of Father	All Teen Mothers		All Unmarried Teen Mothers Who Report Age of Father
	Married %	Unmarried %	%
Younger than 18	3.0	4.3	12.7
18-19	21.5	10.3	30.0
20-24	59.8	15.2	44.3
25-29	11.8	3.2	9.4
30+	3.5	1.3	3.7
Not stated	0.5	65.7	
Percent of all Mothers in Marital Status	45.9	54.1	

Source: Adapted from Karen Pittman, Advocate's Guide to the Numbers, Children's Defense Fund, Washington, D.C., 1988, using unpublished data from the National Center for Health Statistics.

(a) Data on the age of fathers is collected from information recorded on the birth certificate. This information is not always reported.

3. A portrait of the putative father

The Young Unwed Fathers Project[9] reports that, in general, young putative fathers come from all geographical, income and racial groups, although the higher the family income, the lower the likelihood of unwed fatherhood (Lerman, 1987). In general, they:

* Do poorly in school: boys with poor basic academic skills are three times more likely than their peers to become teen fathers (Sklar, 1987).

* Are unemployed: unwed fatherhood is "inexorably" linked with unemployment and skill deficiencies (Sklar, 1987).

* Live with their parents: this is the case for more than half of young, unwed fathers (Lerman, 1987).

Young Black men appear to have a greater probability of being unwed parents than their peers of other races, but this may be misleading because White, never-married boys and men are more likely to underreport their fatherhood.

The Unwed Fathers Project asks if unwed fathers are "just unlucky" or if they follow a pattern. It cites research indicating that these fathers may be predictable (Smollar and Ooms, p. 25). One analyst says young, unwed fathers tend to have a "fair amount of chaos" in their lives and that they view fatherhood as "just another accident of life". Their non-father peers, however, view themselves as having more control, and perceive fatherhood as more disruptive to their goals and lives. Researchers report some evidence of

[9] References in this section are to reports prepared for the Young Unwed Fathers Project (Smollar and Ooms, 1987).

histories of drug use, criminal behavior and lower educational achievement among young, unwed fathers. These behaviors are apt to distinguish young White unwed fathers from their non-parenting White peers. Young Black and Hispanic fathers also exhibit these patterns, but the behavior does not differentiate them from their ethnic peers who are not fathers (Lerman, 1987).

Although the popular perception is that unwed fathers "walk away" from their children, researchers for the unwed fathers project report that many see themselves as involved with, caring for, and loving their children (Connor; Elster; and Sander, 1987). In 1984, 80 percent of young unwed fathers ages 19 to 26 lived away from at least one of their children, but half visited the children at least once a week (Lerman, 1987). However, young unwed fathers are less likely to pay child support than separated or divorced fathers. In 1985, fewer than 18 percent of unmarried teen mothers (18 and younger) had court-ordered child support arrangements. Only 14 percent reported that they received any support (Smollar and Ooms, p. 14).

G) Abortion: U.S. and Alaska

This section provides statistics on abortion among teen women in the nation as well as in Alaska. Readers should remember that abortion statistics for Alaska are no more than estimates based on percentages in nearby states, because no systematic record is kept of abortions performed on Alaska residents.[10]

[10] The Alan Guttmacher Institute bases its estimate of abortions in Alaska on data from nearby states with similar degrees of urbanization: Idaho, Washington and Oregon (Henshaw, pers. comm., 1989). The Centers for Disease Control bases estimates on other states in the region, in this case, Region X.

1. Abortion in the U.S.

It has often been noted that the United States has the highest teen pregnancy and teen birth rates of any industrialized country. It also has the highest teen abortion rate (Djerassi, p. 245). The U.S. teenage abortion rate is actually above some countries' teenage pregnancy rates, a fact which has attracted the notice of numerous commentators. About 30 percent of all abortions performed in the U.S. each year involve teenagers (Hayes, p. 58). See page 106 of this report for U.S. trends. The statistics for 1985 (Henshaw and Van Vort, p. 87):

* Among every one thousand young U.S. 15-19 year old women, 44 had an abortion.

* This rate is far higher than the rate for any developed country.[11] It is 69 percent higher than that in Hungary with the next highest rate and more than twice as high as any other known teenage abortion rate (Henshaw et al, p. 13).

* Teens accounted for 26 percent of all U.S. abortions in 1985 and 13 percent of all births (Henshaw and Van Vort, p. 85)

* If 1985 rates continue, by their 18th birthday nearly one in eleven (nine percent) of young U.S. women will have had at least one abortion. Another one in eleven (nine percent) will have had one or more babies. By the time they are 20, the portion having abortions is about one in five (18 percent) and the portion having births is also one in five (20 percent) (Henshaw and Van Vort, p. 86).

[11] Developed countries are Australia, Canada, New Zealand, Japan, the United States and those of Europe.

The statistics can also be stated in other terms:

Abortions among all teen women. One approach is to look at abortion among all teen women. About 11 percent of all U.S. teen females ages 15 to 19 become pregnant each year; about five percent have babies; about 4.4 percent choose to have abortions. The remainder have miscarriages (Henshaw and Van Vort, Table 2, p. 86). Miscarriages and stillbirths are more frequent among teenagers than among adult women (Hayes, p. 124).

Abortion among pregnant teens. Among pregnant teens, about two fifths -- 40 percent -- chose abortion in 1985. Portions vary slightly by age. For example, among pregnant teens under age 15, 46 percent choose abortion. The portion drops to 43 percent for pregnant teens ages 15-17 and to 41 percent for those ages 18-19 (Henshaw and Van Vort, p. 86). Among girls under 15 there are about 1.4 abortions for every live birth (Hayes, p. 58).

Meanwhile, about 13 percent of teen pregnancies end in miscarriage (American College of Obstetricians and Gynecologists Fact Sheet, 1987). Adding these statistics together shows that more than half of all U.S. teen pregnancies end before term.

Abortion by state. The Alan Guttmacher Institute estimates that the highest teen abortion rates are in California (7.9 percent of teen women), New York, New Jersey, Hawaii and Maryland and Alaska (a tie). Lowest rates are in Utah (1.5 percent of teen women), Kentucky, North Dakota and South Dakota. Researchers believe that less urbanized states tend to have lower rates, perhaps because women lack accessible abortion services.

Highest teen pregnancy rates are reported to be in California (15.1 percent of teen women), Alaska, Georgia, Texas and Arizona. Lowest pregnancy rates are in Minnesota (6.2 percent of teen women), Iowa, South Dakota and Wisconsin (Henshaw and Van Vort, p. 88).

> "Abortion is chosen heavily by teenagers. It's really a teenage pregnancy issue and the more you as a legislator can do to prevent these pregnancies, the more likely it is that you will eliminate abortion as an issue."
>
> -- Connecticut State Rep. Mary M. Mushinsky
> National Conference of State Legislators
> Annual Meeting, 1985

2. Abortion in Alaska.

Alaska keeps no record of pregnancies which end before term.[12] Stanley Henshaw, deputy director of research at the Alan Guttmacher Institute, estimates that nearly 41 percent of Alaska teen pregnancies ended in abortion in 1985 (very close to the national average). By his calculations, one thousand pregnant Alaska teens (through age 19) had abortions in 1985, while another 1,100 carried the pregnancy to term (Henshaw and Van Vort, p. 87).

Using Henshaw's estimates, the state abortion rate in 1985 was one third higher than the estimated national average and higher than all but five other states. Henshaw ranks Alaska's adult abortion rate at 15-16th (pers. comm., 1989).[13]

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[12] Alaska keeps a tally of state-funded abortions for low-income women. From July 1988 to April 1989, the state paid for 575 abortions for women of all ages. Average cost per abortion was $500, not including transportation. There is no record of state-funded abortions by race or age (Landes, pers. com., 1989).

[13] The Guttmacher Institute estimates Alaska's abortion rate at 59; the birth rate at 66; the pregnancy rate at 144. Births are from the Centers for Disease Control and population is from Market Statistics, a private company. No Alaska data exist to check the abortion rate, but the birth rate is a little higher than estimates using current state labor department population statistics.

Henshaw reports the following estimated teen abortion rates in Alaska by age group in 1985 (Henshaw et al, p. 27-9):

* Among one thousand 15-19 year old Alaska teens (pregnant and not pregnant), 59 chose abortion.

* Among one thousand 15-17 year old Alaska teens, 41 chose abortion.

* And among one thousand 18-19 year old teens, 89 chose abortion. The numbers rise with age because teens are more likely to be sexually active as they get older. Nationally, rates peak at age 18, drop slowly until age 21 and then fall more rapidly with increasing age (Henshaw and Van Vort, p. 86).

Using data from nearby states with similar urbanization -- Washington, Oregon and Idaho -- Henshaw reports the following number of Alaska teen abortions, births and pregnancies by age group in 1985 (Henshaw and Van Vort, p. 87):[14]

	Under 15	15-19
Abortions	30	970
Births	13	1,099
Pregnancies	50	2,390

Alaska Native teens have a high birth rate and probably do not have a high abortion rate, according to state teen pregnancy expert Peter Scales of Anchorage (pers. comm., 1989). One factor may be that federal Indian Health Service Hospitals stopped routine abortions in 1981. The state, however, pays abortion costs, including transportation, for Native and non-Native women who fit strict income standards. A single pregnant woman cannot qualify for a

[14] The number of Alaska teen births reported by Henshaw in April 1989 is slightly lower than June 1989 statistics used in this report.

state-funded abortion unless her income is below $453 a month with no more than $1,000 in total resources, including any savings and insurance (Landes, pers. comm., 1989). Scales advocates that the state begin keeping records of abortions and miscarriages as a first step toward accurately assessing the extent of teen pregnancy in Alaska.

H) Living Situations of Alaska Adolescent Parents

No systematic data is kept on the living situations of Alaska teens and their children. Harvard economists David Ellwood and Mary Jo Bane estimate that nationwide as many as three quarters of teen mothers live with their parents the year after the baby is born (Allen, p. 11).

"Adolescent pregnancy is a rapidly growing societal problem that cannot be ignored by government at the state level...There are no automatic solutions to a problem that has become part of the cultural norm for some segments of society and which recurs in successive generations of the same family.

"The responsibility for addressing the issues of adolescent pregnancy and childbearing can no longer be left to the private sector, non-profit organizations and social service agencies.

Pregnancy and childbirth among adolescents must become a major concern of state government..."

-- Preamble
Adolescent Pregnancy Model Legislation
Temple University

But there are some Alaska pregnant teens for whom living with parents, before or after the baby's birth, is not an option. The only licensed residential home for them in Alaska is the Salvation Army's Booth Home in Anchorage, which provides care for homeless girls. With funding cutbacks, the home reduced its beds for pregnant teens from eight in 1985 to two in 1989 and cut to one week the time a new mother can stay after the baby is born to learn how to parent her child (Murphy, pers. comm., 1989). Program Director Donna Teekell says girls often come with no prenatal care as well as no place to live: "They

> "They just do an EPT test and they know they are pregnant because their stomachs are sticking out."
>
> -- Booth Home's Donna Teekell

just do an EPT (early pregnancy test) and they know they're pregnant because their stomachs are sticking out." She says demand for beds for pregnant teens is "phenomenal". Teekell estimates that six homeless girls were referred to the home in the first six months after the opening of Covenant House, a shelter for Anchorage homeless youth. In the Summer of 1989, six teens were on the Booth waiting list, but Teekell calls the list "meaningless". The two current residents, girls from Juneau and Eklutna Village, both had several months to go before they delivered their babies, too late for waiting pregnant homeless teens.

Booth officials work with the state and other agencies to find living quarters and prenatal care for overflow demand. Teekell says the "lucky" ones get into state foster care. Others go to friends or extended family. Some go to shelters for abused women (where their stay is limited) or to a "holding" facility in Fairbanks which is not equipped to provide treatment, therapy or training in parenting, according to Joyce Murphy of the home's board of directors. Some are "out of luck" and go back to the street.

The Booth Home, with an on-site school for residential and day students (who include abused children), has an 87 to 88 percent success rate in getting new mothers back to school or through the GED, Murphy says. Murphy credits "wonderful" teachers. "They don't teach French IV at this school," she says. "They teach how to write checks, take baths and raise a child." Finishing school is vital, she says. She cites as a success story a young mother of two who visited the home for a reunion with the staff in August. She had had "several" pregnancies as a homeless teen, kept one child and obtained her GED through the home. She married, had another baby, went to business college and now is a secretary. "She's planning for her future. She's going to be OK. She's a success," Murphy says.

Once the baby is born, the resident new mother may stay at the Booth Home for one week to practice parenting her baby. Still only children themselves, many had no good parenting models on which to base their own child rearing: some new mothers remember only being hit when they cried. Important in the training is how to cope with a baby when it cries, according to Murphy. "It is very difficult in one week -- or two or three weeks -- to teach these abused children the parenting skills they need," Murphy says. When the week is over, some mothers go to extended family, some to friends and some to foster care. Others go back to "living in boxes in the street" with their babies.

Booth Home also provides out-patient prenatal care, parenting and child birth classes for more than 200 low income and pregnant women, most of them teens (Teekell, pers. comm., 1989).

"Teen pregnancy is the single most important birth control issue in the United States."

-- Carl Djerassi
Co-developer of the birth control pill

I) Is the Age of the Adolescent Mother Significant?

In Alaska, only about one third of births are to girls under 18. Some analysts distinguish between births to young-to-mid-teens and births to older teens on the theory that older mothers are more likely to plan and be able to finance their pregnancies. One commentator complains about discussion in "painful detail" of the "alleged" problems of pregnant girls 11 to 15 years old when little mention is made that these girls compose fewer than two percent of all births to adolescent women (Kasun, p. 1). Another cautions that the phrase "teenagers" misleads because it implies school-age, although fewer than half of all teen births are to "school-age" girls (Richard, p. 2). The implication is that 18 and 19 year olds may have finished school, are more likely to be married and less likely to have problems than younger mothers.

> "Unless we take strong and clear actions now, teenage pregnancy in Alaska will increase and so will the social and economic problems that accompany it."
>
> -- Governor's Interim Commission on Children and Youth

However, being 18 guarantees neither graduation nor marriage. A national study in the late 1970's shows that nearly one in five (18 percent) women who had a baby at age 18 or 19 had not finished high school ten years later and the portion is larger for younger teen mothers (Pittman 1983, p. 4). Nearly half of all Alaska 18 and 19 year olds who give birth are unmarried when the baby is born (Vital Statistics, June 5, 1989). Finally, the Alaska infant mortality rate averaged over five years shows that babies born to 18 and 19 year old mothers had a higher infant death rate than those born to 15 to 17 year old mothers (Silverman, pers. comm., 1989).

Chapter III

IN ALASKA: THE PUBLIC COST

The public pays more than $51 million a year to support families of Alaska mothers who had children when they were teenagers. Of this, $4 million a year is spent to support parents who are currently adolescents and raising children. These are conservative estimates: public costs are defined as state and federal Aid to Families with Dependent Children (AFDC), Food Stamp and Medicaid costs only. Many significant costs of teen pregnancy and childbearing are not included in this report. For example, a teen parent may rely on public support to complete her education and enter the job market -- at a high short-term cost to the taxpayer (Hayes, p. 134). Other costs not counted here are child care while the parent is in school, foster care for homeless teens and their children, protective services for an abused teen or her child, housing, and psychological counseling, as well as the partial loss of mother and child as productive members of society.

These are costs of teen <u>births</u> only. Costs of teen <u>pregnancy</u> are not included because the state does not keep a record of abortions or miscarriages. Using data from other Western states, researchers estimate 2,400 Alaska teens became pregnant in 1985 (Henshaw and Van Vort, p. 87). This is almost seven pregnancies a day. More than half are believed to have ended in abortion or miscarriage. Teen pregnancies which do not come to term can have high public and private costs. Some Alaska teens are caught in an unhealthy, abusive or incestuous cycle and, without intervention to help them break out of the pattern, become pregnant again and again (Murphy, pers., comm., 1989). The costs of intervention, miscarriage and abortion are not included, nor are the cost-benefits of prevention.

This chapter also does not treat the private price paid for a lifetime by some teen mothers, their children and their grandchildren. This cost is the poverty of a 37 year old grandmother who earns $6.50 an hour because in 1969 she got pregnant instead of a diploma. It is the depression of a 17-year-old daughter, single, a dropout and expecting her second child. It is the cerebral palsy of a two-year-old granddaughter, born too soon and without prenatal care. And it is the predicted failure of a yet unborn grandchild, already at risk to drop out of school.

An estimated 2,200 young Alaska mothers are not yet 20 years old. Some will overcome their poor prospects and find security for themselves and advantages for their children. Others will never finish school, never get job training and never earn above-poverty wages. Some of their children are already abused, already neglected, already behind in developmental scores and already at risk to become teen parents themselves.

From a public policy point of view, it is unwise to ignore Alaska's children having children: poorly educated, poorly trained and poorly prepared, some will have difficulty helping themselves and their children to self-sufficiency. Ultimately, everyone pays the price of indifference. Increasingly, the private sector is feeling the effects. "Girls who have babies at age fifteen, sixteen, or even younger frequently become permanent dropouts from school and society, forever dependent on government support," writes the Committee for Economic Development (CED), a research organization of over two hundred business executives and educators (CED, p. 24). It adds that without an education, teen parents, their children and their grandchildren are unable to hold jobs which, more and more frequently, require "literate workers with good problem-solving skills -- workers who have learned how to learn" (CED, p. 5). The business leaders conclude that much of the cost of welfare paid and productivity lost could be avoided. Teens must have the chance to finish their education and gain the experience, perspective and patience which help make parenting easier. In a word, they need time and opportunity to grow up.

The costs described in this chapter are estimates based on the latest available number of Alaska teen births and dollars spent in public assistance benefits. They are summarized below and described in more detail in a later section. See Appendix II for method, assumptions, sources and formulas used in calculations.

> "The long-term costs to society and the (teen) mother can be extremely high... No one believes it is good for children to have children."
>
> -- David Ellwood
> Poor Support

A) Summary of the Costs of Adolescent Parenting in Alaska

* **In 1988, the public spent $51.4 million to assist Alaska families that were begun when the mother was a teenager.**

These are costs of direct payments and administration for Medicaid, AFDC and Food Stamps only. This is referred to in this report as "Single Year Costs".

* **In 1988, the public spent an estimated $4 million to assist Alaska mothers who are still in their teens.**

This figure is based on actual benefits paid to families headed by Alaska teens in January 1989. It includes direct payments and administrative costs of AFDC, Medicaid and Food Stamps only.

* **It costs more than $12,000 a year to support a welfare family headed by an adolescent.**[15]

The estimate is based on actual benefits paid Alaska teen families in January 1989. It includes administrative costs and benefits for Medicaid, Food Stamps and AFDC only.

* **By the time they reach age 19 (in the year 2006), the group of babies delivered to Alaska teenagers in 1987 will cost the public $21.5 million (in 1988 dollars).**

Twenty-year costs vary with the number of babies born in a given year. Babies born in Alaska in 1986 will cost $21.1 million; babies born in 1985 will cost $20.9 million; those born in 1984 will cost $23.5 million and so on. These are costs of AFDC, Medicaid and Food Stamps. This is referred to in this report as "Single Cohort Costs".

B) Methods and Sources

Two methods of calculating costs are used in this report. The first -- cost of mothers who began parenting as teenagers -- was devised by the Center for Population Options. The second -- cost of parents who are still in their teens today -- is adapted from a formula produced by the Children's Defense Fund. Cost of benefits is provided by the Alaska Department of Health and Social Services Division of Public Assistance. The tables in Appendix II show benefit amounts and number of births assumed for the calculations.

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[15] Coincidentally, this is roughly equivalent to the cost of one year's tuition and board and room at a moderately priced out-of-state public or private college.

To calculate the cost of mothers who began parenting as teenagers, AFDC, Food Stamps, and Medicaid benefits and administrative costs are averaged over 20 years and multiplied by the probability that a teen will live independently from her family (making her eligible for welfare) and have more children. The center estimates that if all teens delayed childbearing until they were adults, the public could avoid paying only 40 percent of money now spent for teen parenting (circumstance will force some mothers to apply for assistance, no matter how educated or trained they are, or how old they were when their first child was born).

To calculate the cost of families of parents who are teenagers today, average monthly AFDC, Food Stamp and Medicaid benefit and administrative costs are multiplied by the number of teen mothers receiving welfare in an average month.

> "The consequences of too-early childbearing are so devastating and far reaching they can hardly be ignored."
>
> -- Charles Stewart Mott Foundation

C) The Costs: Alaska Mothers Who Began Parenting as Adolescents

The Center for Population Options estimates the cost of all mothers who were adolescents when they had their first child. Researchers estimate that when these mothers go on welfare, they receive assistance for an average of eight years (Pasquale, pers. comm., 1989). The center reports that in 1987, the U.S. public paid $19 billion to support mothers who began their parenting as teens. "Next year we will pay $19 billion more, and we will pay another $19 billion the year after that," the center's executive director wrote in a letter to the New York Times in October 1988. Comparable public assistance costs (AFDC, Food Stamps and Medicaid only) in Alaska are shown below.

1. Single Year Costs.

In 1988, the public spent $51.4 million on families that were begun when the mother was a teenager.

These are the public outlays every year to assist Alaska families begun (some years ago, some recently) when the mother was an adolescent. These are not costs of women who are currently teen mothers only. In other words, these are the cost of teenagers having had children in the past. For assumptions and calculations, see Appendix II, Table 1 (Single Year Costs).

Had all these births been delayed until the mother was an adult, the public could have avoided spending $20.6 million in 1988.

This assumes that if all teenage pregnancies were delayed, the public could avoid paying 40 percent of the costs.

2. Single Cohort Costs.

All families begun by Alaska teenagers who had a first baby in 1987 will cost the public $21.5 million over the next 20 years (in 1988 dollars).

This is an estimate of what one cohort of babies -- that is, all first babies born to teenagers in one year -- will cost by the time these babies reach adulthood. For assumptions and calculations, see Appendix II, Table IV (Single Cohort Costs).

If these births had been delayed until the mother was an adult, the public could avoid spending $8.6 million over the next 20 years (in 1988 dollars).

This assumes that if all teenage pregnancies were delayed, the public could avoid spending 40 percent of the costs.

D) The Costs: Alaska Parents Who Are Adolescents Today

The Children's Defense Fund concentrates on the cost of supporting U.S. parents who are still under age 20 today. In 1986, defense fund researchers put the cost at $2.7 billion a year (Allen, p. 13). Comparable costs for Alaska are shown below (AFDC, Food Stamps and Medicaid only). Costs are based on actual welfare benefits paid to needy families headed by Alaska teenagers in January 1989.

1. Annual Cost: All Current Families of Adolescents

In 1989 alone, the public will pay an estimated $4 million in public assistance to Alaska teenage parents and their children.

These are costs for families in which the parent is still a teenager today. Once the parent grows to adulthood, the family is not included in cost estimates -- even if the family is still receiving public assistance. For assumptions and calculations, see Appendix II, Table V (Single Year Costs: Families of Current Teens).

2. Annual Costs: One Family Headed by an Adolescent

In 1989, the cost of public assistance for one teenage mother and her children was $12,160.

This is based on a monthly average of 335 welfare families headed by a teenager (identified from the January 1989 caseload by the state Department of Health and Social Services, Division of Public Assistance). Like other welfare recipients, teen families move in and out of the welfare system, meaning that over the year, a larger total number of teen families receive public assistance.

E) How Much Can Be Saved?

Both the Center for Population Options and the Children's Defense Fund are adamant that wiping out teen pregnancy would not end welfare costs. They stress that even if every Alaska female waited until she was an adult to have her first child, circumstance -- divorce, death, bad luck -- would still place some on the welfare rolls, no matter how well educated or well trained.

Children's Defense Fund researchers consider only costs of parents who are still in their teens today. This lowers the estimated cost of teen pregnancy because it eliminates any welfare family in which the mother is over age 19. They do this deliberately, believing that it is "naive" and "misleading" to speak of saving substantial amounts of money in the short term (Pittman 1988, p. 13). They say the cost to repair the problems which cause teen pregnancy will be so enormous that there may be few short-term savings: we can delay teen childbearing, but if we don't make other changes, we are "only buying time" (Pittman 1986, p. 10). Delaying childbearing without using those years

to improve a teen's education and training merely means that teens who find themselves unmarried, unemployed, dropouts and parents at 18 would -- even if they waited until age 20 or 25 to have a baby -- still be unmarried, unemployed and dropouts. Delaying pregnancy is only one step. The other steps:

"If we are not equally aggressive in helping those teens build up deficient academic and work-related skills, gain concrete work experience, and get into college, a training program, or an occupation that has some potential for generating a decent wage, we have not solved the problem -- we have only delayed it."

The Center for Population Options reasons, on the other hand, that women who began childbearing as teens are less apt to have had the opportunity or desire to pursue their education or learn the job skills that will keep them and their families off welfare. Martha Burt, the author of center's cost analysis Teenage Childbearing: How Much Does It Cost?, writes, "Teenage mothers have a statistically higher probability of receiving welfare at some time in their lives than do women who delay childbearing. Loss of schooling and higher fertility reduce the mother's ability to support herself and her children and increase public costs." (Burt 1986, p. 222). Whatever the mother's age, the fact that she began having children when she was in her teens increases the probability that she and her children will cost the public money.

F) Alaska Adolescent Parents On Welfare

Many people believe adolescent mothers are almost sure candidates for welfare. However, an analysis of 1976 Census data by the Urban Institute found only 34 percent of married and unmarried mothers younger than 20 were living in AFDC

households, either as household heads or in subfamilies. Both the Children's Defense Fund and the Center for Population Options accept that estimate (Allen, p. 11; Burt and Haffner, p. 12).

The Alaska Department of Health and Social Services analyzed the welfare caseload for one month -- January 1989 -- to show a moment in time. Tables 9a, 10a and 11a in Appendix I present the results.

In summary, if the chosen month is typical, 335 Alaska families headed by parents under age 20 receive public assistance monthly. (A larger number of adolescent-headed families receive welfare annually because families move on and off the welfare rolls in the course of a year.) A closer look at the chosen typical month shows that (Lomas, pp. 1-3):

* More than half (56 percent) of Alaska teen parents receiving assistance are age 19 and another 30 percent are age 18. In January 1989, only one 14-year-old and no 13-year-olds received AFDC.

* Nearly four fifths of Alaska teen mothers on welfare have one child. (This includes 73 percent with one child and six percent in their last trimester of pregnancy).

* More than two fifths (44 percent) of the Alaska teen families on welfare live in the Anchorage public assistance area. Another 14 percent live in the Fairbanks area. Eight percent live in Kenai, eight percent in Wasilla and nearly 7 percent in Ketchikan. Fewer than four percent live in each of the remaining areas which are, in descending order: Bethel-Southwest, Juneau, Southcentral-Northwest-Rural, Northern Rural, Kotzebue, Nome, Sitka and Fort Yukon.

Chapter IV

STUNTED LIVES: THE CONSEQUENCES OF TEEN CHILDBEARING

If teen parenting is so expensive and cost-benefits so elusive, why try to fight it? The answer lies in the toll it takes on the teen mother, her child and the society in which they live. Teen parenting does more than wound two children: its injuries spread outward to society and forward to succeeding generations. Many teenage mothers and their children overcome the handicaps and find their way to economic and social recovery. But studies show that a "substantial portion" of these families do not do well (Hayes, p. 138). This chapter describes the consequences of teen parenting on both parent and child.

> Teenagers need a "positive aging vat" where they can prepare for a career. For the non-marginal student, this vat is school. For the marginal student, there is no such environment.
>
> -- Gary G. Wehlage
> University of Wisconsin

A) Consequences for the child

Every child needs certain advantages in order to be a self-sufficient adult: good health, preparation for work that pays above-poverty wages, a dose of self esteem and the knowledge that one can make a difference in one's community. But children born when their parents were still children may miss out. Parenting is a difficult enough task for anyone; it is much harder when

attempted in the poverty, isolation, depression, hopelessness, marital instability and unpreparedness which afflict many very young parents. Among the risks to children of teens:

* Children of adolescents are at risk to be born too small. Low birthweight children are more likely to suffer long-term medical conditions such as mental retardation, cerebral palsy, epilepsy and other injuries. They are 20 times more likely to die before their first birthday than babies born at normal weight (Institute of Medicine, p. 29. Fifty percent of deaths in the first year of life are attributed to low birthweight (U.S. General Accounting Office, p. 13).

* Once they survive the neonatal period, children of adolescent mothers are more likely to be hospitalized and are more likely to die of injuries, violence and infections (Comfort et al, p. 955).

* As they grow, they display more physical, emotional, behavioral and developmental difficulties than do children of older parents (Comfort et al, p. 955; Moore and Burt, pp. 32-3). Several studies show that children of teen parents are at greater risk of "social impairment": poor anger control, feelings of inferiority . They are at risk to be rebellious and aggressive. One study found a high incidence of school behavior problems, substance abuse and early sexual experience (Hayes, p. 136).

* They are more likely to fail in school (Pittman 1987a, p. 6). Spivak and Weitzman point to one 17-year follow up study showing that over 50 percent of the children had repeated grade. As early as eight months, children of teens score lower on standardized developmental tests and these differences persist throughout childhood (Spivak and Weitzman, p. 1500). The National Research Council reports they score consistently lower on IQ tests and vocabulary and block design tests. A child's IQ

scores appear to decline by about one point for every year of schooling the mother does not complete. In one study, every additional year of a mother's education reduced the likelihood that the child would be retained in grade by almost 50 percent (Hayes, pp. 135-6).

* They are at risk to be abused or neglected and to have psychosocial problems (Comfort et al, p. 955). Almost 50 percent of the children of teenage mothers in a 17-year follow up study had been suspended or expelled from school within the preceding five years and 16 percent had run away from home at least once (Spivak and Weitzman, p. 1500). Moore and Burt report the pattern of social and emotional problems is less distinct than with cognitive deficits (Moore and Burt, p. 33). Although educators and social workers expect a higher incidence of abuse, learning disabilities and delinquency among children of adolescent mothers, the National Research Council reports these may be the result of socioeconomic conditions and family structure. When these two factors are controlled, teen mothers do not appear more likely to abuse or neglect their children than other mothers. One researcher theorizes that poverty strongly affects early pregnancy and abuse (Hayes, p. 137).

* Finally, children of teen parents tend to become parents themselves at an early age and the span between generations is shortened. One quarter of adolescent daughters in one sample had already had a pregnancy in a 17-year follow up study (Hayes, p. 136).

B) Consequences for the Parent

Adolescent mothers are more likely than other teens to be single, poor, isolated, school dropouts and depressed. Among the statistics:

* More than half of U.S. teen mothers are unmarried when the baby is born and 96 percent of unmarried teens nationwide keep their babies (Alan Guttmacher Institute, pers. comm., 1989).

* Teen mothers who marry before or after the birth face a high probability of divorce (Moore and Burt, pp. 20-1; Scales, pers. comm., 1989).

* Families headed by single women with children are the poorest of all major demographic groups in the U.S. and families of young single parents are at greatest risk. Two thirds of children in young female-headed families live in poverty (Johnson et al, p. 48-9).

* Teen mothers are often depressed or socially isolated. They may be frightened and angry and in conflict with their own parents (Comfort et al, p. 955). Several studies suggest that the most important influences on children's adjustment are the overall level of maternal functioning and consistency. There is accumulating evidence that a major factor for childhood psychopathology is maternal depression (Spivak and Weitzman, p. 1501).

* The suicide rate of teen parents is seven times that of teens who are not parents (Kenny, p. 1).

* Only half of pregnant teens obtain early prenatal care (Pittman 1987, p. 4). Adolescent mothers are three times as likely as older mothers to delay getting prenatal care or to get no care at all (Institute of Medicine, p. 151). Inadequate prenatal care is a major factor in the infant's increased risk of physical and mental handicap.

* Because they begin earlier and have fewer life goals, teen parents may have larger families and more closely spaced children than do older parents (Hayes, p. 129; Moore and Burt, pp. 21-2).

* Studies of mother-child interaction show teen parents may be more authoritarian and rigid than older parents. Studies show that they begin conversation with, talk to and look at their infants less frequently than older mothers (Spivak and Weitzman, p. 1503). While noting this, however, the National Research Council cautions that it is "simplistic" to assume teen mothers are poor parents (Hayes, p. 137).

* Teen parents often have poor math and language skills and have an increased chance of dropping out of school. Moore and Burt report the educational attainment of school-age mothers never approaches that of women who delay childbearing past the teen years. Only half of teen parents manage to attain a high school diploma, compared to 96 percent of those who delay the first birth until age 20 (Moore and Burt, pp. 17-8). Karen Pittman of the Children's Defense Fund states that whether the young woman is Black, White or Hispanic, she is three times as likely to be a teen parent if she has poor basic skills. One half of 16 to 19 year old mothers ranked at the bottom of their age group in reading and math skills; teen fathers also ranked below other boys (Pittman 1986b, pp. 4-5).

* Sixty one percent of all teens who had babies in 1983 had not completed high school. Almost 20 percent had not completed ninth grade (Pittman 1987a, p. 5). The National Research Council notes that while many young women drop out of school when they give birth, many others drop out during the year before the birth of their child (Hayes, p. 126). It is no longer legal to prohibit a pregnant teen from attending school. Title IX of the Education Amendments of 1972 (implemented in 1975) prohibits publicly supported educational programs from discriminating on the basis of pregnancy.

The likelihood that a teen might not finish high school is of more concern today than it was a generation ago when fewer jobs depended on a diploma. In

1960, a high school dropout could expect to earn almost 90 percent of what a high school graduate earned. By 1980, the dropout made only 70 percent of the high school graduate's earnings (Pittman 1986a, p. 4). Between 1973 and 1986, the median earnings of high school dropouts under age 30 who head young families fell by more than half. And for dropouts under age 25, earnings fell by more than 70 percent. Today a child living in a young family headed by a female high school dropout is 14 times more likely to be poor than a child in a young married couple family headed by a college graduate (Johnson et al, pp. 29 and vii).

With untimely parenting, prospects for a healthy and independent life are significantly reduced. "While the popular image of severe and life-long social and economic disadvantage for adolescent mothers is exaggerated, women who begin childbearing as teenagers are nevertheless at greater disadvantage than those who delay childbearing," says the National Research Council. Very young mothers face heightened risk of pregnancy complications and poor birth outcomes. Their infants face grater health risks and greater likelihood of death. Teenage marriages may be unstable. And teenage parents, male and female, have less schooling, less job training and fewer opportunities. Teenage mothers, because they begin their families earlier, often have more children than do mothers who put away childbearing until they are adults. Less education, single parenthood and little chance for work experience put mothers who begin parenting as teens at risk to earn less than other women, although they may be supporting larger families. Not all very young mothers fall prey to these difficulties. We will see in the next chapter that for those who do, the consequences of teenage childbearing -- poverty, curtailed education and their companion, hopelessness -- are also among its causes.

Chapter V

THE CAUSES OF ADOLESCENT PREGNANCY: A DOUBLE-EDGED SWORD

What are the causes of teen pregnancy, so costly in terms of dollars, so chilling in terms of human potential? There is no neat answer to this difficult question. In the National Research Council's Risking the Future published by the National Academy of Sciences, a panel of experts asks (Hayes, p. 262):

> Why do young people who are hardly more than children themselves become parents? Is it due to a lack of individual responsibility, maturity, knowledge and values? Or does it result from the pervasive problems associated with poverty, including limited education and employment opportunities, and among many high-risk youth, growing up in a fatherless family? The answer to both of these questions seems to be yes.

Teen pregnancy expert Peter Scales of Anchorage agrees. He adds, however, that teens with advantages, maturity and high hopes also get pregnant. Professionals feel more comfortable talking about children with problems, says Scales, the author or more than 100 books and articles and frequent keynote speaker at teen pregnancy conferences around the nation. "But kids who like school and get good grades also get pregnant in Alaska. They aren't having trouble, but they are having sex and they're not using birth control" (pers. comm., 1989).

Research shows that today most American young people become sexually experienced while in their teens. The question appears to be how early in their adolescence they begin intercourse and whether they are married.

There is evidence from the National Survey of Family Growth that more than 80 percent of males and 70 percent of females report intercourse before their 20th birthday and that the probability of intercourse increases with age (just under 17 percent of boys and six percent of girls reported they were sexually active before they were 15). However, less than half of all unmarried teenage girls in the United States are sexually active (Hayes, p. 40). A girl's initial sexual partner tends to be about three years older than she is; a boy's is approximately one year older, according to a 1983 Family Planning Perspectives article by Melvin Zelnick and F. K. Shah (Hayes, p. 96). Researchers at the University of Rochester Medical Center note the desire for "spontaneity" among very young adolescents and suggest that very young teenagers may not possess sufficiently developed ability to recognize that intercourse is a choice and that it can result in pregnancy if contraceptives aren't used. The National Research Council points out, however, that research in press at the Alan Guttmacher Institute shows that "even young sexually active teenagers can effectively avoid pregnancy" (Hayes, p. 101).

The council reports that certain behaviors appear linked to early sexual activity. For example, researcher Richard Jessor finds that sexually active teenagers are frequently involved in other conduct that pushes toward independence. (Among the most frequent behaviors are smoking, drinking and drug use, but researchers do not fully understand the extent to which there may be a causal link). Other observers, such as Frank Furstenberg writing in Unplanned Parenthood: The Social Consequences of Teenage Childbearing, note that early dating is linked to early sexual activity. Among girls, frequent dating is also linked to early sexual activity, according to a 1976 paper presented at the National Institute of Child Health and Human Development Conference.

This chapter presents expert opinions into the causes of inopportune teen pregnancy and childbearing. It begins with a summary of the National Research Council survey of scientific literature to learn what causes early sexual activity. This effort, published in 1987 by the National Academy of Sciences, is the most complete discussion to date of research in this rapidly advancing field.

A) Why Teenagers Become Sexually Active.

The National Research Council concludes that the decision to have sexual intercourse at a young age is related to (see Hayes, Ch. 4):

1. Early pubertal development. Early initiation of sexual activity is "strongly associated" with early development, especially among boys. Among girls, hormonal levels have strong effects on sexual interest but only weak effects on sexual behavior. J. R. Udry and others conclude that girls' actual behavior is influenced more by their social environment than by their physical maturation (Hayes, p. 96).

2. Community standards and expectations. Differences in community attitudes affect the acceptability of early sexual behavior. Numerous studies show that Black adolescents become sexually active about two years earlier than their White peers (Hayes, p. 97). Researchers disagree on why. Some attribute the disparity to socioeconomic differences, others to differences in attitude (a difference some believe is caused by social and economic disadvantage). Some studies suggest that neighborhoods and length of time a family has been poor make a difference. Some believe long term disadvantage affects a family's outlook on marriage and the family and that this affects how

the family regards early sexual behavior. Data from the 1982 National Longitudinal Survey of Youth shows that youth from lower socio economic status tend to initiate sexual activity at earlier ages (Hayes, p. 44).

3. Religiousness. Teenage females who are regular church attenders are less likely to have early sexual activity, according to a 1981 report to the National Institute for Child Health and Human Development. The research council concludes that religious teens may be more traditional in general than other teens and less likely to engage in behavior that pushes them toward adulthood. They may also have stronger social supports to enforce these values.

4. Intelligence and academic aspirations. A number of studies show that young men and women who score low on intelligence tests and place little value on education are more likely to have sexual intercourse early. M. Davies and D. Kandel, writing in the American Journal of Sociology, find that parents' level of education and their aspirations for their children can significantly influence the child's own attitudes toward academic achievement. Teenagers with well-educated mothers are more likely to postpone initiation of sexual activity, according to data from the 1982 National Longitudinal Survey of Youth. Among boys, the portion having had intercourse by age 18 increases from 56 to 62 to 72 percent as the mother's education declines from beyond high school to high school graduate to dropout. Comparable portions for girls are 34, 41 and 54 (Hayes, p. 44). Researchers find that parents with more education are less likely to be poor and their children tend to be more goal-oriented, more interested in achievement and more oriented to work than play (Hayes, p. 101). The National Research Council notes that the portion of sexually active teenagers is higher among those enrolled in schools with "high" dropout rates -- more than 10 percent (Hayes, p. 45).

5. Parenting. Studies find a link between the parent-child relationship and sexual activity -- but researchers disagree on what that link is. A number of studies have found that adolescent girls are more likely to have intercourse if their mothers "fail to combine affection with firm, mild discipline and to set clearly defined limits on behavior" (Hayes, p. 102). However, others suggest that the perceived decline in the closeness of a mother-daughter relationship follows the first sexual activity, rather than preceding or causing it. Richard and S. Jessor find teens less likely to become sexually active when teens and their parents have coinciding values, a sense of connectedness and close ties. Others, however, point out that less parent-child communication takes place than is commonly assumed, that the child may not hear what the parent is communicating and that communication about sexual behavior frequently doesn't begin until after sexual activity has started. An American Institutes for Research 1984 study found no relationship between frequency of pre-sexual-activity communication with parents and the sexual activity of the daughter. The same study found that for boys, communication with the mother was associated with less subsequent sexual activity, while communication with the father was associated with more. Cheryl Hayes, writing for the National Research Council, reports that research shows that girls from "nonintact or female-headed families" are more likely to have early sexual experiences, but that researchers disagree about why. Some suggest that the cause is stress. They believe the stress of parental separation or divorce and the presence of several siblings may cause children ("especially daughters") to perceive a lack of attention and affection from their mothers. Others suggest that this stress makes it difficult for parents to supervise their teenagers. Some, however, suggest that when there has been a divorce, parents ("especially mothers") may indirectly communicate an attitude of permissiveness.

B) Which Sexually Active Teens Use Contraceptives?

The National Research Council reports that the older the teenage female is when she begins sexual activity, the more likely she is to use contraception. In addition, older teenagers are more likely to use contraceptives regularly and effectively and to choose a "prescription" method, primarily the pill, while younger girls are more likely to be sporadic contraceptive users and to rely on "male" methods such as the condom and withdrawal.

The council's survey of research shows the following determinants of whether teenagers use contraceptives (see Hayes, Ch. 4):

1. Academic aspirations and achievement. Girls with clear educational goals and expectations and good performance in school are more likely to use contraception. Similarly, the better educated the parent, the more likely the sexually active teenage woman is to use contraceptives. The Panel on Adolescent Pregnancy and Childbearing draws these conclusions from a series of reports written in the 1970's and early 1980's.

2. Knowledge of reproduction and contraception. Available research shows that most teenagers have a general understanding of contraception and know that a girl can get pregnant if she has sex, according to Kristin A. Moore and other adolescent pregnancy experts. But Melvin Zelnik and F. K. Shah have questioned adolescent females and find that many do not know enough of the basic facts to use contraception effectively (Hayes, p. 108). Many girls feel erroneously that they are too young to get pregnant; and many who do successfully avoid pregnancy when their bodies are immature come to believe they are immune and do not need contraception. A U.S. Department of Health and Human Services report confirms that knowledge about sex and contraception are linked with greater frequency of contraceptive use among both male and female teenagers. The National Research Council states that the issue is not

whether more sex education should be directed at teenagers -- "it should". What is critical, however, is the need to develop a better understanding about the relationship between what young people know and how they behave. A small sample of model sex education programs shows that such programs are very effective at increasing level of knowledge about contraception, but have "little impact on...whether (teenagers) became sexually active and whether they used contraception" (Hayes, p. 109).

3. Acceptance of one's own sexuality. Several studies have found regular and effective contraceptive use among teenage girls who accept their own sexual behavior (who acknowledge that they are sexually active). A girl's inability to acknowledge that she is sexually active may inhibit her use of contraceptives. An often-quoted report by Melvin Zelnik in 1981 shows that many teenagers, especially young ones, delay using contraceptives for up to a year after they become sexually active. Other studies show that teens with a "low level of guilt" about their sexual behavior use contraceptives more effectively. Most studies in this area concentrate on the girl; the little research available on teenage boys shows that knowledge about and attitudes toward birth control are very important to contraceptive use. A 1975 survey by Finkel and Finkel of contraceptive knowledge among male teenagers finds "levels of knowledge (among boys) appear to be quite low" (Hayes, p. 110).

4. Personality characteristics. The National Research Council says that certain teenage females appear more likely to use contraceptives effectively. They are those with a high level of self esteem who perceive that they have a large measure of control over their lives and that they are competent and capable of choosing and shaping their destinies. A 1980 study for the U.S. Department of Health and Human Services finds that adolescent females who are passive and hold

traditional attitudes about female dependence are generally poor contraceptors. The same study finds that teenage males who are "impulsive, socially irresponsible and oriented to risk taking" tend to be poor contraceptive users (Hayes, p. 110). Girls who are impulsive, who find it difficult to plan ahead and who are risk takers also have poor records of contraceptive use.

5. Parental support and control. Family background appears to be less directly related to teenage contraceptive use than are mother-daughter communication about contraception and the mother's support of the daughter's use of contraceptives. Several studies indicate that if a sexually active teenage female has good lines of communication with her mother and her mother is a source of information about birth control, she is likely to be a more frequent user of contraceptives. These mother-daughter discussions, "even if they are isolated or infrequent", appear to positively influence teenage contraceptive use, as does family support in seeking family planning services and following a birth control regimen (Hayes, p. 110-11). Similarly, the type of maternal discipline appears to play a role. E. Flaherty and J. Maracek, in a final report to the National Institute of Child Health and Human Development, write that daughters who are limited by rules and who are punished for violating them by having their privileges restricted are more likely to use contraceptives.

C) Which Pregnant Adolescents Decide to Bear a Child?

Recent research reports that willingness to bear a child outside of marriage is closely related to the "opportunity cost" of doing so. Researchers find that "low-income teenage females with low academic and occupational expectations living in single-parent families" think of the opportunity costs of early childbearing as very low "since their willingness to risk such parenthood" is "quite high". These conclusions are presented in a 1985 paper by A. F. Abrahamse and others at the annual meeting of the Population Association of America in Boston.

Is a teen's willingness to bear a child related to availability of Aid to Families with Dependent Children? The existing body of research (four studies published between 1974 and 1984) suggests that there is "no evidence" to support this assumption, the National Research Council concludes. It cites a New York City study published in 1974 finding no significant differences in attitudes and behaviors about childbearing among welfare recipients and nonrecipients. David Ellwood and Mary Jo Bane of Harvard University conclude that "unmeasurable" differences in culture, attitudes and expectations -- rather than differences in levels of welfare support -- explain differences in birth rates to unmarried teenagers.

Frank Furstenberg has found that, while unmarried girls do not get pregnant in order to receive assistance, girls from low-income and female-headed families (many receiving welfare already) are more likely to become single mothers themselves. Kristin A. Moore and S. Caldwell in 1977 suggested that the availability of welfare may make it easier for a young pregnant woman to choose single parenthood over abortion, adoption or marriage. However, their study found little empirical evidence that welfare benefit levels affect decisions to become sexually active, to become pregnant, to marry, to have an abortion or to release a child for adoption. The study notes that "the vast majority of adolescent pregnancies are unintended and welfare is only one of

a number of factors that influence teenagers' decisions regarding pregnancy resolution" (Hayes, p. 119).

The National Research Council identifies certain characteristics it says are frequent among early unmarried childbearers:

1. Personal characteristics. The council cites a paper presented at the 1985 annual meeting of the Population Association of American which shows a "strong relationship" between rebelliousness (for example, disciplinary problems in school) among adolescent girls and willingness to become an unmarried mother (Hayes, p. 118).

2. Parenting. The same paper shows that girls who say they "rarely" talk to their parents about their plans and activities are more willing to have a child outside of marriage. Girls who say their parents are less likely to monitor and keep track of them are also more willing to be unmarried mothers.

3. Poverty and unemployment. Numerous studies show a close relationship between poverty and poor employment opportunities and nonmarital childbearing. These conditions may be the root of feelings of futility which lead to the perception that the teen parent has little to lose. But unemployment and poverty may also make marriage unmanageable for a teen couple expecting a baby (Hayes, p. 119).

4. Attitudes toward nonmarital childbearing. National researchers look carefully at the difference in rates of unmarried childbearing among Blacks and Whites because such births are much more prevalent among Black than among White teens (Hayes, p. 117). Although Alaska's Black population is small, research of this nature into childbearing among minority teenagers may provide some direction for those interested in adolescent pregnancy and parenting among Alaska Natives.

Researchers believe that the diversity of family forms among Blacks makes single parenthood less unusual and provides more socially acceptable opportunities for accomodating young Black single mothers and their children. One researcher into survival mechanisms in the Black community finds a network of support among low-income urban Blacks that helps cushion young mothers from the conditions of life in poverty. Another, Kristin Moore, says Black families "seem to be more supportive" of young mothers and that this supportiveness may ameliorate a teenager's fear of becoming a young mother. At the same time, Moore also finds that, despite the greater tolerance, unmarried parenthood is generally viewed as "unfortunate". Very few pregnant teenagers at a low-income Baltimore clinic said their mothers were pleased by the pregnancy. Most were "hurt and depressed or angry" (Hayes, p. 117).

D) Risk Factors That Lead to Early Childbearing.

Louise Flick of St. Louis University, working through the Danforth Foundation in the mid-1970's, identified decisions that lead to teen pregnancy and the characteristics of adolescents likely to make those decisions. Flick believes teen parenthood is the last step in a continuum. The first is the decision to have sexual intercourse. Once that step is taken, the adolescent, male and female, must consciously or unconsciously, decide whether or not to use contraceptives. And, if pregnant and unmarried, the female must decide whether to abort or continue to term. If she has the baby, she must decide whether to keep it or place it in adoption. The "risk factors" leading to each decision are listed in the box on page 70 (Foster, pp. 36-42).

Risk Factors

Poverty, low educational goals, school failure, drugs and alcohol, difficulty talking with parents, inaccurate information about sex, poor self concept, peer pressure.

The research quoted above shows that being poor and a minority make it more likely that an adolescent in these groups will have a baby. But this does not mean that the majority of teenagers who give birth are poor and of a minority race. Because the U.S. population is weighted toward people who are non-minority and above the poverty line, two thirds of U.S. teenagers who give birth are white and two thirds live in families with above poverty incomes

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E) Lack of Hope in a Better Future

Booth Memorial Home's Joyce Murphy reports that pregnant teens who seek help at the home are frequently physically and sexually abused, have little sense of self worth and less hope. "At 13, these babies having babies can't ever imagine having worse experiences than those they have already lived through," she says. They have a baby because it is something they can love that will love them. "It's a teddy bear, essentially," Murphy says. "What happens? It's like a puppy dog. Inevitably it's going to pee in the bed and the child that is its mother won't be able to cope."

Scales adds that young people at risk to become parents don't see themselves "looking down the road and making things happen". They don't know where they

fit in; they have a sense of hopelessness. Especially vulnerable, he says, are Alaska Native young people, with a teen birth rate more than twice the national average.

"One of the best contraceptives (for teens) is hope," says the Children's Defense Fund. Poor teens who are failing in school do not believe pregnancy will close doors because they already believe that no doors are open to them (Pittman 1986b, p. 4).

The Committee for Economic Development suggests the causes of teen pregnancy are low self esteem, peer pressure, too much free time, need for love, need for a sense of purpose (CED, p. 25). Educator William Glasser believes teen pregnancy results from a lack of belonging and a lack of power. Pregnancy -- not child rearing -- satisfies the needs. "But it does so in a way that is almost always self destructive for immature mothers" (Brandt, p. 40).

The Children's Defense Fund sums up (Pittman 1986, p. 8):

> If we want to reduce the rates of pregnancy and parenthood among these teens, we have to make their childhoods more cherished and their adulthoods more rewarding. They need to believe that, at age 15, they have several years of growing and learning and reaching ahead of them that they do not want to lose. They need to believe that they will have much more to offer a child at age 25 than they have at 15. These are not things that we can tell our youths to believe. These are things that we have to show them.

F) The Influence of Television: Lots of Sex, No Contraception

The director of the Center for Population Options implicates television, a "peer" influence. Television shows 20,000 references a year to sex; 70 percent of them show intercourse between unmarried people. "Yet there are virtually no references to contraception," says the center's Judy Senderowitz (Carnegie, p. 4). Scales agrees. "Out of all those portrayals, you hardly ever see effective birth control, or someone saying 'no' because they don't want an early pregnancy, and feeling good about it." It isn't just television programs, says Scales. It is exposure to the "one-sided and unrealistic attitude" of a whole culture.

HOW CHILDREN FAIL

Teen boys and girls who are parents are at high risk to fail in school. There may be many reasons.

* They may come to school poorly prepared for classroom learning.
* Their parents may be indifferent to their educational needs.
* They may be the children of teenagers ill-equipped for parenting.
* They may have undiagnosed learning disabilities.
* They may have language problems.
* They may experience racial or ethnic prejudice.
* They may have access only to schools of substandard quality.

-- Adapted from Children in Need
Committee for Economic Development

Chapter VI

WANTED: "A LEADER WITH GUTS AND COURAGE"

This chapter presents for discussion proposals by state and national experts on how to attack what most authorities agree is an important social problem. It begins with recommendations by two Alaskans. The first, Peter Scales of Anchorage, is a nationally recognized expert on adolescent pregnancy whose research is frequently cited in the literature. He is followed by Joyce Murphy, head of the board of directors of the Booth Memorial Home, which provides shelter and care for Alaska homeless pregnant teens. Recommendations by national groups follow. The chapter ends with a discussion of the pros and cons of contraceptive education and counseling for adolescents. Although the proposals described in this chapter weave a sometimes disparate and diverse fabric, the reader will recognize common threads.

A) Recommendations from Alaskan Experts

In states where teen pregnancy is fought successfully, the governor and/or legislators have taken the lead, according to Scales, who has been both chair and vice-chair of the Governor's Interim Commission on Children and Youth. Alaska needs "a leader with guts and courage" to set goals and continue them, he says. "We have enough data on the enormous social and economic costs to know that it is our own fault if we don't invest and we have enough data to know what works."

To be successful, efforts should start at the preschool age, Scales says. He believes giving a 15 year old "a few hours" of sex education "while making it hard to get birth control" will not curb teen pregnancy. The successful program will be a "15 year investment" (pers. comm., 1989).

Among Scales' Alaska-specific recommendations (pers. comm., 1989; Alpha News 1987, p. 1-2):

1. Provide courses in life skills.

"First and foremost", Alaska school districts must be required to develop courses in life skills, Scales says. These classes should teach the ability to think critically, evaluate options, envision consequences, anticipate the future and make effective decisions. They should also educate students about sexuality -- "not just sex education".

2. Teach social connectedness.

Alaska adolescents should learn to "connect" with their community, to discover that what they do makes a difference to the world and the community, according to Scales.

3. Provide adult mentor-examples.

At-risk Alaska youth should have "mentoring relationships" with an older person outside of the teen's family, school or employment. Scales describes this person as a "life skills coach" enough like the young person culturally, economically and socially, that the child can see there is a road that leads somewhere for him or her. These programs show "enormous impact" in helping young people at very high risk of becoming parents "because they involve giving to others and being given to."

4. Create conditions in which self esteem can grow.

Self esteem includes self worth and self efficacy. Self worth is feeling good about oneself, Scales says. But self efficacy, often overlooked, may be more important: it shows children they can have an impact on the life they live.

5. Provide easy access to health care.

Young people should have easy access to "front-line" health care, Scales says. If health clinics were in or near schools, children would have that access. Clinics provide basic and regular physical and mental health care, "and for a lot of kids, there is no other health care available." Health clinics should offer contraceptives and contraceptive counselling, Scales says.

6. Reduce the dropout rate.

Alaska must increase its efforts to help all young people stay in school, especially Native youths, whose dropout rates are higher than those of non-Natives. Scales recommends financing "alternative" schools for at-risk youth.

Alaska has no statewide dropout data. The federal Department of Education reports that Alaska ranks 41st in the nation in rate of high school students who graduate. Our graduation rate is lower than the national rate (67.7 percent v. 71.1 percent). Only nine states and the District of Columbia have a worse record (Associated Press, May 2, 1989). These rates do not include students who drop out before they reach high school.

7. Help teens who are already parents.

In addition, teens who are already pregnant need a continuum of options, Scales says. Among them are legal abortion, adoption assistance and help with parenting. There must be school-based day care for teen parents. Parenting

teens need comprehensive medical services, contraceptive counseling, career training and home-visitors to give example and advice.

After years working on the front line for Alaska's only residential home for pregnant and homeless teenagers, Joyce Murphy, a veterinarian who heads the executive board of the Salvation Army's Booth Home, makes the following suggestions (pers. comm., 1989):

8. Teach sex education in school.

Murphy believes that "hiding sex education under the couch or the desk" won't keep children from experimenting. If they don't get information about their sexuality from their parents -- and many do not -- they will go to the "wrong sources". "It is better to have it taught by people who know, by experts, than to have children learn it behind the lockers in the gym," she says.

9. Make abortion available to teens.

Saying she sees a difference between an abortion for a 13-year-old and an abortion for a 35-year-old, Murphy calls terminating a pregnancy "one viable option" for a teenager. But she stresses that any pregnant teen considering her alternatives should be carefully counselled about her goals, desires and self esteem and how to achieve them. Murphy is concerned that unwanted teen pregnancies ruin two lives:

* Dysfunctional pregnant teens may give birth to babies damaged for life by drugs, alcohol, abuse or poor nutrition. "So many pregnant teenagers are dropouts, so many are from dysfunctional families, so many have enormous needs, so many are abused, so many abuse drugs and alcohol that even if they carry their baby to term, it is at risk."

* At the same time, the pregnancy comes before the girl has learned what she must learn before she can be a successful parent: to be a more mature, stable individual. She needs time to assimilate the skills to hold a decent paying job, to be self sufficient, to resist peer pressure, drugs and alcohol, and to like herself.

"If we want to stop this mess and get these children -- and their children -- off the public welfare rolls, we have to give them an option to get themselves out of the gutter," Murphy says. One option is abortion.

10. Teach self worth.

Murphy believes at-risk Alaska teens must be helped to recognize they are important human beings and that "drugs and alcohol and having babies at 13" are not ways to find love. They need to feel self worth, self respect and the knowledge that they can be constructive contributors to society. Instead, she says, many think it is "macho and 'in' to have sex at 10". They refuse to listen when confronted with the dangers of AIDS, herpes and hepatitis, as well as pregnancy, because they are risk takers who believe "it can't happen to them".

"Do you realize that? They just have a baby and start parenting with no training at all."

-- Joyce Murphy, Booth Home

> "The first high school graduating class of the 21st Century completes kindergarten this year. These are our future workers, teachers, taxpayers and leaders. But we may never know them. Today, too many die before their first birthday; too many are born in poverty; too many become parents before they become adults."
>
> -- National Governor's Association

11. Teach parenting.

Murphy believes that educating for parenting -- "the most important job in the world" -- is essential. Most people begin parenting with no instruction and little experience, other than the example of their parents. "Nevertheless, we expect them to just do it. Do you realize that? They just have a baby and start parenting with no training, no education at all".

12. Schools have a responsibility

The biggest source of information for most young children is school, in and out of the classroom, Murphy says. People expect children to learn about sex, parenting and other life skills at home, but many children from all income levels have few or no positive models, no good examples at home. Schools need to begin early to teach children how to set goals and achieve them; how to make good decisions; how to increase their own self esteem; and that they and their bodies are "the most important things in the world to them". Schools need to help children learn to resist peer pressure and that "it is OK to be quiet and alone, that they don't always have to have groovy times with their friends". Children should learn early that television isn't the answer and that pregnancy isn't going to increase their self worth, Murphy says.

B) Recommendations from National Experts

The National Research Council, the Children's Defense Fund, the Council of State Policy and Planning Agencies and the conservative think tank Committee for Economic Development offer suggestions on how to combat teen pregnancy. Their recommendations are summarized below.

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1. The National Research Council

In 1987 the National Research Council issued Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing. The council (affiliated with the National Academy of Sciences) uses scientific evidence to set priorities in policy and programs to combat teen pregnancy.

The council is "unequivocal" in its belief that the primary goal should be reducing the rate and incidence of unintended pregnancy among adolescents, especially those of school age (Hayes, p. 266). Preventing pregnancy would result in fewer births and fewer abortions. There are several strategies toward this goal:

* Enhance life options of disadvantaged teenagers
* Delay the initiation of sexual activity
* Encourage contraceptive use for sexually active teenagers.

Among the approaches to this goal, only one -- encouraging contraception among sexually active teens -- is endorsed by the council as having "demonstrated effectiveness" (Hayes, p. 6). The panel finds little evidence" that the first two strategies are effective, but the it endorses the

development and evaluation of such programs as a basis for future policy and program decisions.

a. The Council's Endorsement: Encourage contraception.

The Panel on Adolescent Pregnancy and Childbearing concludes that modern contraception (especially the pill) may have helped liberalize society's attitudes toward sex and that this may have influenced adolescent behavior. But it continues: "(T)here is no evidence that the availability of contraceptive services per se has caused increased sexual activity among teenagers, male or female." In fact, many adolescent girls are sexually active a year or more before they obtain contraceptives, the panel says. It adds: "This must be changed."

The Panel on Adolescent Pregnancy and Childbearing concludes (see Hayes, pp. 272-76):

* The contraceptive pill is the safest and most effective means of birth control for sexually active adolescents.

* Aggressive public information is needed to dispel myths about the health risks of pill use by girls in this age group.

* Contraceptive service programs should explore nonmedical models for distribution of the pill.

* There must be continued public support for contraceptive services to adolescents. Available services to teenagers depend heavily on funding through Title X of the Public Health Services Act, Medicaid and other federal and state maternal and child health programs. These programs should minimize barriers of cost, convenience and confidentiality.

* Sex education programs should include information on methods of contraception, how to use them and how to obtain them. The panel points out that in several European countries, sex education that provides information concerning contraceptive methods (including how to obtain and use them) is associated with earlier and more diligent contraceptive use by adolescents, especially use of the pill (p. 273).

* A variety of contraceptive service models -- including private physicians -- should be available to adolescents at low or no cost. Providers should improve the effectiveness of their programs by aggressive outreach efforts to encourage early use; explore effective counseling approaches to encourage compliance; improve follow-up of clinic patients to track whether they are using contraceptives. Providers should be sensitive to the concerns and apprehensions of teenagers.

* School systems should develop and refine comprehensive school-based clinics for implementation and evaluation in schools with high-risk populations. Clinics that provide teenagers with contraceptive services in the context of comprehensive adolescent health care can reach a large number of young people. These clinics have the advantage of encouraging male involvement in contraception by attracting boys, who use them for other health needs such as athletic physicals. The panel calls school-based clinics "promising". It adds that they are relatively new and experimental and require careful evaluation.

* Condoms should be distributed in programs aimed specifically at young men. Distribution programs do not require special clinic facilities.

* There should be studies about the effects of paid promotional contraceptives messages directed at sexually active adolescents. Studies of factors affecting attitudes and behavior in European countries suggest that contraceptive advertising may be one means of increasing teenagers'

awareness of these methods and make them feel that the methods are available. The panel states: "There is no evidence to suggest that advertising alone will directly alter behavior." It adds that the media's potential for influencing teen attitudes about desireable models of behavior (including sexuality) is "significant" (Hayes, p. 276).

b. Enhance the life options of disadvantaged teens.

Unless adolescents want to avoid pregnancy, other prevention efforts may have little positive effect, the report says. For many, however, motivation to "delay immediate gratification and avoid pregnancy" has been sapped by the "negative odds of intergenerational poverty," the council says. Among the deleterious effects of poverty on those caught in its cycle: attitudes of fatalism, powerlessness, alienation and helplessness (Hayes, p. 267).

Teens need a reason to believe that parenthood is inappropriate at this stage, the panel concludes (Hayes, p. 267). One way to combat this is to enhance life options by encouraging teens to establish career goals "in addition to parenthood" and help them to understand the value of educational attainment and employability skills. Although there is little research clearly demonstrating the effectiveness of this approach, the council recommends four programs for development and evaluation (Hayes, pp. 267-69):

* Life-planning courses
* Programs to improve school performance
* Employment programs
* Role-model and mentor programs

c. Encourage teens to postpone sex.

Young teens may have trouble seeing how the decision to have sex can have lifelong consequences, the council says. For them, pregnancy and parenthood are often "distant, intangible abstractions". Although there is little available evidence to document their effectiveness, the panel suggests the following interventions:

* Establish family life and sex education classes. Although such courses are widely available in school systems nationwide, they vary substantially in their content, comprehensiveness and quality. They also vary in the extent of parent and community involvement in their planning and implementation. The council finds that "education programs that are combined with other approaches (assertiveness and decision-making training and role modeling) may help reinforce family values, responsible behavior and self control" (Hayes, p. 270).

* Teach assertiveness and decision-making skills. Evaluation of one program using this approach is now underway, the panel says. It says that positive results might warrant replication.

* Involve the media. The panel says that personalities and heroes of television, movies and rock music are "among the most pervasive influences" on adolescents. Several groups are exploring ways to encourage the media to present more realistic and responsible portrayals of personal and sexual relationships, but the panel says incentives for network executives to alter their current messages and models are "weak" (Hayes, p. 271).

d. Show alternatives to childbearing and parenting.

The Panel on Adolescent Pregnancy and Childbearing believes prevention of pregnancy through abstinence or contraception is "far preferable" to unintended pregnancy among teenagers. Yet, it adds, there is little evidence that available strategies significantly influence the timing of sexual initiation. It would be "disingenuous" to shrink from considering the difficult choices facing the "unmarried pregnant child or woman", the panel says. These choices: abortion; bearing the child and raising it; adoption.

The panel stresses the need for "objective, nonjudgmental" option counseling and support services. It urges (Hayes, p. 278):

> At each step along the path from sexual initiation to parenting -- regardless of whether one might wish that step had not been reached -- the girl or woman should be treated with the same dignity, confidentiality, kindness and excellence of health care that are due any patient.

Among the recommended alternatives and interventions:

* Abortion. The council finds no scientific basis for restricting the availability of abortion for adolescents (Hayes, p. 278). It says the contention that adolescents are unlikely or unable to make well-reasoned decisions or that they are vulnerable to serious psychological harm as a result of abortion "is not supported" (Hayes, p. 277). In addition, there is no evidence that requiring parental involvement in the decision serves any purpose other than to "ensure that parents are aware of what their adolescent daughters are doing". On the contrary, requiring minor teenagers to seek parental consent often causes them to delay abortions with attendant health risks.

Concern that availability of abortion services will lead to higher rates of teen sexual activity and pregnancy and less reliance on contraception "is not supported by available research", the panel says. In fact, adolescents who have had abortions are less likely to have a repeat pregnancy within two years than are those who have given birth (Hayes, p. 278).

The panel reports that in general, health risks associated with an early, legal abortion are no greater for adolescents than for adult women. They are less significant than risks of pregnancy and childbirth.

* Encourage pregnancy testing and counseling. Early confirmation of pregnancy is important to preserve options and minimize health risks.

* Encourage abortion counseling and parental and partner involvement. Although counseling for parents is not typically provided, it "may be a useful way of enhancing the family's capability to provide emotional support". Contraceptive counseling is also an important part of abortion counseling.

* Adoption. The council also recommends strengthening adoption services, improving decision-making counseling and developing models for providing care to women who choose adoption. The popularity of adoption appears to have declined over the last 20 years, especially since abortion was legalized. Although research on adoption is limited, it suggests that adoption services are often fragmented and poorly coordinated and that they frequently focus on the prenatal period but overlook the young woman's need for support and help after delivery (Hayes, p. 280-81).

e. Improve the health of teen families.

The council recommends lowering bureaucratic barriers that "prevent teenagers from receiving early, regular and appropriate care for themselves and their children". This would include:

* Continued support for prenatal care, labor and delivery care, and pediatric care through Medicaid; the Early and Periodic Screening, Diagnosis and Treatment Program; other federal and state maternal and child health programs.

* Contraceptive services should be available and accessible to adolescent parents at low or no cost. Many adolescents who give birth have repeat pregnancies within two years, the panel reports. Most did not take effective steps to prevent conception.

f. Improve the economic well-being of the teenage family.

Ensuring the economic well-being of families headed by teen parents until they become self sufficient is "an essential strategy". Two interventions (Hayes, pp. 286-88):

* Encourage child support enforcement. Fathers should be involved in the financial support of their children, the panel says. Parents are obligated to provide support until their children are 18, the panel says. Even if the father's current level of financial help is low, his contribution may increase over time.

  The panel urges:

(1) Young men should be educated about their child support obligations.

(2) Efforts should be made to link child support to education and work requirements in the form of registration with the state employment service and participation in job training and job search activities.

(3) At a time when states are adopting "workfare" for welfare mothers, including mothers of very young children, it is appropriate to consider similar programs for the fathers who young children.

The panel notes that some states (Wisconsin and Hawaii) have inaugurated grandparent liability, but that no data exist to show whether such a provision will serve the larger purpose of strengthening family bonds.

* Change AFDC benefit requirements. The council believes AFDC regulations "constitute an incentive for a teenage mother to establish independent living arrangements, thereby undermining her family's obligation and ability to provide financial and emotional support". The 1984 Deficit Reduction Act amendments to the Social Security Act require that teenage parents eligible for AFDC and living with their parents must be included in a household grant. But minor mothers living away from their families are also eligible to receive benefits on their own. The panel offers a suggestion: link the receipt of AFDC benefits by adolescent mothers to remaining in their parents' home, except under conditions that pose a physical or emotional hazard to the adolescent or her baby (Hayes, p. 288).

g. Enhance life options for teenage parents.

All the efforts to improve health and prevent new pregnancies may have little effect until teenagers can be persuaded to "invest in their own futures", the

panel observes (Hayes, p. 288). Many teenage mothers and fathers aspire to the same future as their peers who delay childbearing: a nice home, a good job and a loving spouse. But they frequently have difficulty envisioning in concrete terms how to make this happen. The panel suggests several approaches:

* Life management training to help parents establish goals and achieve them, parenting education and child care. Teenage parents need to have realistic dreams of what they can be -- in addition to being a parent. And they need to understand how to reach these dreams, one step at a time, the panel says.

* Support for success in education. "Most" adolescents who become mothers before graduation do not finish high school; the same is true for "many" adolescent fathers with parenting responsibilities (Hayes, p. 288). The relationship between parenthood and dropping out of school is complex. Many teens who have unhappy records at school are at risk to drop out when they become pregnant; others had already left school before they became pregnant. For these young people, parenthood may look better than the dismal prospect of unsuccessful experiences in school. "Yet adolescent parents must be made to recognize that finishing school is essential", the panel says. It recommends intensive remedial education and self-paced instruction, alternative school programs, home instruction or television instruction (Hayes, p. 289).

* Employment programs. Continue efforts to strengthen age-appropriate employment programs for pregnant girls and teenage parents, both male and female. Regardless of child support, 18 and 19 year old teens need job training and placement. Providers must consider the related needs of these young parents: child care, transportation, counseling. Lack of these services can significantly affect a teen parent's participation and outcomes. Pay particular attention to improving a teenage father's chances for employment and decent wages (Hayes, p. 290).

* Support model child care programs targeted to the needs of teen parents. "Young parents who have access to and use child care...are more likely to finish high school and enter the job market" (Hayes, p. 290). This care must be convenient and affordable. It must provide "emotional support and guidance to young parents who may not fully understand their roles and responsibilities". Schools and other community organizations should place high priority on establishing and maintaining child care services.

* Develop case management for teenage parents (in which one person is responsible for helping the teen get all the services and benefits she needs). Simply putting services in place in the community will not ensure that teenagers will benefit from them, the panel says (Hayes, p. 291). Many high-risk adolescent parents require intensive individualized attention and care.

h. Help the children of adolescent parents.

The documented problems suffered by children of teenage parents are only partly the direct result of their mothers' young age and lack of schooling. They are also affected by poverty, poor nutrition, low birthweight and living in a single-parent household, the panel says (Hayes, p. 291). It recommends one intervention:

* Parenting education. Schools and other community organizations should place "high priority" on developing, putting in place and evaluating parenting education programs. Such programs should be available and sensitive to the developmental requirements not only of infants and toddlers but of the teenage parents themselves. Teenagers who have not grown up in supportive, enriching families may have little positive basis for modeling their own parental behavior, the panelists say.

2. The Children's Defense Fund.

The Children's Defense Fund's Adolescent Pregnancy Clearinghouse publishes six reports a year examining the nation's teen pregnancy crisis and its solutions. Among suggestions in the reports:

a. Improve education and work experience.

Teens with poor basic academic skills are more likely to become early parents. To counteract this, the defense fund recommends an education that "fuels rather than dampens" interest (Pittman 1983, p. 7) Education should allow children to "experience success before they experience failure" (Pittman 1986, p. 14). In Adolescent Pregnancy: What Schools Can Do, the defense funds recommends that schools and communities:

* Identify young children who are falling behind and expand programs for them.

* Strengthen dropout prevention efforts (including self-paced remedial instruction, vocational preparation and work experience).

* Involve parents and community groups in efforts to help disadvantaged youths. School personnel should be sent out into the community.

* Build community support for sexuality education (including health education, family life education, life planning and decision making).

* Help disadvantaged students attend college (including counseling and guidance directed at these students).

* Review unmet health needs among students and encourage the community to find a means of providing health services to teens who don't have them.

* Encourage community service projects such as cross-age tutoring (to bolster student responsibility and sense of self worth).

* Work with community organizations to expand recreational or social programs to bolster self esteem and non-academic achievement.

* Set up school-to-work transition programs in cooperation with business leaders and youth employment agencies.

b. Discuss sex and sexuality in school and at home.

"All teens need sexuality and parenting education," the defense fund says in Adolescent Pregnancy: An Anatomy of a Social Problem in Search of Comprehensive Solutions. Defense fund researchers find a "strong and growing sentiment" that schools can do more to help teens delay pregnancy. Among specific suggestions:

* Schools should "move toward timely and accurate" presentation of information on sexuality. Although "the single most important factor" determining whether a district has a sex education or family life program is the school superintendent's perception of community support, research shows that once sex education is in place "far less than five percent" of parents ask to excuse their children from it.

* Parents should be involved and, equally important, they should be encouraged to supplement school instruction with "more personal and informal" opportunities for guidance.

c. Provide contraceptive services.

While early and adequate sex education is vital, it is effective "only" if teens can get the services they need, the defense fund says (Pittman 1986, p. 11). It suggests:

* One way to provide them is through health clinics. A comprehensive adolescent health clinic, located on or near a school, is an extension of two programs "that should be in all schools": family life/sex education courses and health services.

* But not all schools need clinics, not all clinics need to be located in the school and not every school clinic needs to distribute contraceptives, the defense fund says.

d. Provide counseling.

In order to increase their ability to delay pregnancy, teens need "opportunities for discussion and guidance" (Pittman 1986, p. 12). This "personal" process of discussion with adults and peers sharpens their values and helps them assess the values of others. "At its best", classroom sex education offers this discussion. Often, however, it is available in smaller, more informal groups such as Girls Clubs, Boys Clubs, Y's and churches. School-based clinics also provide counseling.

e. Combat poverty and its effects

It is clear that America has a task that stretches well beyond sex education and contraceptive services, the defense fund says in Adolescent Pregnancy: Whose Problem Is It? Children at risk are those whose families, schools and

communities do not provide the incentives to delay parenthood and help them toward self sufficiency. The public must make more up-front investment in a population "in which we thus far have only punily and grudgingly invested" (Pittman 1983, p. 8).

f. Use the media.

The defense fund distributes teen pregnancy prevention posters, 60-, 30-, and 10- second radio spots and television spots produced by Fallon McElligott and Charles Guggenheim Productions. (The Center for Population Options also uses the media to increase communication about sex. Its Adolescent Media Project tells teens about options, choices and responsibility. The center produces radio announcements with celebrities and operates a referral "hotline".)

g. Other ideas from the Children's Defense Fund

The defense fund also describes the need for child care for the children of young mothers. This is essential if they are going to complete their education or job training and become self sufficient. It encourages after-school and summer programs for teens. And it focuses on increasing child support enforcement for children born to teen mothers.

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3. The Council of State Policy and Planning Agencies

The Council of State Policy and Planning Agencies, in a manual for gubernatorial planning officials (Preventing Teenage Pregnancy: A Public

Policy Guide), suggests the following specific options for preventing teen pregnancy (see Foster, Ch. 3):

a. Improve knowledge and attitudes about sex and contraception.

A 1984 evaluation by Douglas Kirby of sexuality education shows that these classes may change attitudes (they appear to make teens more tolerant of sexual practices of others), but not behavior (they apparently have no effect on the student's own behavior toward sex). They do not appear to increase permissiveness in sexual attitudes or increase sexual activity. Kirby's study shows that when these programs are combined with clinic services, they have demonstrated an ability to reduce teenage pregnancies. None of the non-clinic education programs had any impact on pregnancies (Foster, p. 62-3). An Alan Guttmacher Institute 1985 study suggests that the lack of openness about sex in our society is a major factor related to our high incidence of teenage pregnancy. The authors report: "Teenage pregnancy rates are lower in countries with greater availability of birth control and sex education" (cited in Foster, p. 63).

b. Make birth control conveniently and confidentially available.

The council says the location should be easily accessible, there should be frequent follow up and providers should care about the teens they serve (Foster, p. 67). The council suggests that school-based clinics solve the problem of proximity and make follow-up easier. The Guttmacher Institute has found that many teens do not go to traditional family planning clinics (in 1985, only one in seven clients at federally funded family planning clinics were teenagers). A 1982 evaluation of West Dallas family planning program revealed that teens feel as if they "stick out" and may be labeled as "sexually active" if they go to these clinics (Foster, p. 64).

Adolescent health clinics connected with schools show a "remarkable decline" in teen pregnancy, the policy council reports. It cites as an example the West Dallas Youth Clinic of the University of Texas Health Science Center, the first clinic program of its kind (established in 1970). Here "comprehensive health care in a school setting" makes follow up of missed appointments and dropouts easier. A second example is a program operated by the family planning council of Western Massachusetts in cooperation with a vocational high school. An unpublished report prepared for the Centers for Disease Control shows that the clinic led to a decline of more than 50 percent in one year in the pregnancy rate of enrolled students. The program included two afternoon awareness sessions each school year. Participants were referred to a nearby clinic for contraceptive devices. The program has been discontinued because a new school administrator found it "objectionable", the policy council says (Foster, p. 65). The most often cited example of school-based health clinics is the Maternal and Infant Care Program of the St. Paul Ramsey Hospital in St. Paul Minnesota. The St. Paul program, created three years after the University of Texas program, shows "dramatic results." Over a three year period, teen fertility dropped 56 percent. Analysis shows that most teens who did become pregnant delivered rather than aborted. "Thus the decline in births appears to be the result of a decline in pregnancies," the policy council concludes (Foster, p. 66). Kirby reports the St. Paul program provides consultation, conducts pelvic exams, writes prescriptions, helps arrange the filling of those prescriptions and does careful follow-up.

c. Make a "positive aging vat" for all students.

In a paper for the Rockefeller Foundation, Joy Dryfoos says pregnancy is the single largest reason girls drop out of school. But she points out that less than half of girls who drop out do so because they are pregnant. The risks of pregnancy after dropping out are much higher (cited in Foster, p. 67).

The policy council quotes research by Gary G. Wehlage at the Wisconsin Center for Educational Research which concludes that teens drop out of school because it has no "holding power" for them: they have little success in school and do not like it. Wehlage believes all students -- marginal students, like more successful students -- need a place to mature, a "positive aging vat" (cited in Foster, p. 71). For the non-marginal student, the vat is school. There is no "vat" for marginal students. Their school experiences are negative and they are unprepared emotionally or practically for the labor market.

The council recommends "caution" in using full time employment to prevent teenage pregnancy, particularly for the marginal or dropout student. It doesn't help prevent teen pregnancy to force teens into adult roles of self-sufficiency when they are neither emotionally or practically ready. A better prevention strategy would be creating a "safe and constructive" environment in which teens can mature before entering the adult world, rather than "simply finding jobs for dropouts." Creating an environment where the marginal student can have academic success and the ability to sample the world of work will require significant changes in our schools, the council says (Foster, p. 73).

d. Improve family communication about sex.

Joint parent-child sex education classes increase family communication about sex, the council says. Martha Burt and Freya Sonenstein observe that teens who talk with their parents (usually their mother) about sexuality and contraception "delay initiation of sexual activity longer and are better users of contraception when they do begin" (Foster, p. 74).

e. Improve self-confidence, self-esteem, communication, decision-making.

Systematically teaching teenagers the skills they need to influence their environment appears to increase sexual knowledge, problem-solving abilities, communication and use of contraception, the council says (Foster, p. 77). Foster summarizes a four-step plan by Steven P. Schinke to teach responsible sexual behavior (Foster, p. 76):

* Provide access to information on which to base decisions and behavior. Adolescents must have accurate and complete information on reproductive biology, contraception, pregnancy resolution options and the place of sexuality in normal adolescent development.

* Provide accurate perception, comprehension and storing of this information so it can be used as the basis of the new behavior. Perceptual errors are common with adolescents -- they selectively ignore certain information, misread or mishear particular facts or selectively forget information, Schinke says.

* Personalize and use the information.

* Develop behavioral skills to use these decisions in social situations.

f. Reduce risk-taking behavior.

Teens at risk to become pregnant are more likely to take chances with their health and their futures, the council says. Teenagers who come from families that are supportive and nurturing have a lower incidence of problem behaviors. Policy makers should consider "social resistance" programs to teach youths skills to resist risk-taking behavior. But the council identifies as "perhaps the most effective approach", devising methods of supplying the nurturing and

support from families, communities, religious institutions that children "so desperately need" to avoid major risk-taking behavior altogether (Foster, p. 79).

g. Provide adequate income support to counter the effects of poverty.

Poverty is the greatest single predictor of teenage pregnancy, the council says (Foster, p. 80). Teens living in poverty are twice as likely as their non-poor peers to become sexually active at an earlier age and not to use contraceptives. Once a teen becomes pregnant, the likelihood of remaining in poverty is greatly compounded, continuing the poverty-pregnancy cycle through another generation. The council recommends establishing a "sound and workable" employment policy and expanding and using income transfer and in-kind service programs to provide financial support to poor families. These recommendations are "important if not essential" elements of any effort to prevent teenage pregnancy (Foster, p. 80).

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4. The Committee for Economic Development.

In Children In Need, the Committee for Economic Development writes, "Of all the demographic issues currently facing the nation, none is as serious as the alarming increase in unmarried teenage parenthood... Teenage motherhood stunts two lives at once" (CED, p. 24). Young teen mothers frequently become "permanent dropouts" from school and society, the committee says. By the time they are five, children of teen parents are already at "high risk" to be unemployable (CED, p. 9). Not only do teen parents lack the skills to be employed themselves, the committee says. They also lack the resources to help their children learn good parenting and employment skills.

The committee recommends a five-step program to create a "success-oriented" environment for teen mothers and to prevent teen parenting. The steps (see Children in Need, p. 27):

a. Keep pregnant teens and those with babies in school.

This will help them develop the skills to get and keep decently paid jobs, the committee says. It is "the best deterrent" to repeat pregnancies and a lifetime of dependency.

b. Emphasize parenting education.

Programs should instruct teen mothers and fathers in the physical and emotional care of their children, the committee says. Young fathers "ought to share in the responsibility" of parenthood.

c. Provide prenatal and post natal health care and nutritional guidance.

This will help avoid low birthweight which is a common problem of babies born to girls who become pregnant before they are 17. Low birthweight leads to health problems and learning disabilities, the committee says.

d. Provide day care for young mothers in school -- preferably on site.

The rationale is that it is easier for a mother to complete her education if she can be near her children. An on-site location provides an ideal opportunity to use day care to provide parenting education and to provide a stimulating environment for infants and toddlers.

e. Replicate successful programs.

Good programs in the middle grades (six, seven and eight) can help make young people want to plan careers rather than fall into early parenting. For high-risk teens (among them, those who are children of teen parents), the committee suggests as a model the Beethoven Project in Chicago, sponsored by businessman Irving B. Harris and funded by a combination of public and private sources. The project works with teen mothers and their children from early in pregnancy until the child enters kindergarten.

"The most effective form of birth control is education that increases aspirations and provides job skills," the committee says.

C) Contraceptive Education: Cause or Cure?

National surveys[1] show that more and more U.S. teens are becoming sexually active at younger and younger ages. This trend is important to policy makers because each year, one in between five and six sexually active U.S. teens becomes pregnant (Maciak, p. 2071). Perhaps the most controversial of the suggested solutions cited above is contraceptive education and counseling for adolescents. Many who are concerned about adolescent pregnancy disagree with this approach.

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[1] The National Survey of Family Growth, 1982; and three National Surveys of Young Women by M. Zelnik and J. F. Kantner. Sources for this section are S. Hofferth et al, "Premarital Sexual Activity Among U.S. Teenage Women Over the Past Three Decades", Family Planning Perspectives, March-April 1987 and B. Maciak et al, "Pregnancy and Birth Rates Among Sexually Experienced U.S. Teenagers -- 1974, 1980 and 1983", Journal of the American Medical Association, October 16, 1987.

Should young people be taught and counselled about contraceptives in the schools? This questions takes us into murky and politically sensitive waters. Before plunging in, it would be well to look at the trends in birth and pregnancy among American teens between 1970 and today.

In general, sexual activity among teens has become "primarily nonmarital or premarital" (Hofferth et al, p. 46). Among sexually active teens, contraception is up (although very young sexually active teens are slow to start using contraceptives) and so is abortion (particularly immediately after 1974 when abortion was legalized) while pregnancy and birth rates among sexually active teens are down. The statistics look different when teens are considered as a whole. So many more teenagers are having sex that among all teens, the pregnancy rate has gone up. So much of this sex is pre or nonmarital that the birth rate for all unmarried teens has increased.

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1. The Historical Context: the 1970's and 1980's

Sexual activity by unmarried adolescents is up. Adolescent girls are becoming sexually active at younger ages and fewer teenagers are marrying. Sexual activity in this age group rose dramatically in the 1970's and declined slightly (some analysts say it leveled off) between 1979 and 1982. Although they are sexually active, many have intercourse "infrequently" (Hayes, p. 43). Note that the statistics in this section are percents, not rates:

* From 1971 to 1979, the portion of unmarried 15-19 year old females who had ever had intercourse increased from 28 to 46 percent. Between 1979 and 1982, there was a slight decline to 42 percent (Hayes, p. 41). Boys appear to initiate sexual activity earlier than girls, but by the later

teenage years (18-19), the portion of girls who report having had intercourse approaches that of boys.

* Among women born in 1938-1940, two fifths (38.9 percent) reported they had premarital sexual intercourse by age 20. Among women born two decades later in 1959-1961, more than two thirds (68.2 percent) reported they had premarital sexual intercourse by age 20 (Hofferth, p. 49).

Contraceptive use by unmarried sexually active adolescents has increased. Although very young teens are reluctant to adopt contraceptives, use of contraceptives among other unmarried sexually active adolescents has increased since 1970. This use grew steadily during the 1970's and, like sexual activity, leveled off in the early 1980's. The National Research Council reports that in 1976, nearly two thirds of sexually active 15-19 year old teen women said they had "ever" used a contraceptive. By 1982, the portion had increased to 85 percent (Hayes, p. 46).

> "The sexual revolution has moved from the college campus to high schools and has now filtered down to the junior or middle school levels."
>
> -- Temple University National Institute for Adolescent Pregnancy and Family Services

Within two years of initiating sexual intercourse, nearly half of teens who used no contraception had become pregnant, according to research in Volume II of Risking the Future. For those who used "nonmedical" forms of contraception (such as condoms, rhythm and withdrawal), nearly one quarter became pregnant within two years of initial sexual activity. And for those who used "prescription" or "medical" methods (birth control pills, the IUD and the diaphragm), 15 percent became pregnant within two years (Hayes, p. 49).

"Sex makes babies. It's a simple message..."

-- Teresa K. Cummins
Alaska Public Health nurse

What are the trends in kinds of contraceptives used by teens? Use of the pill declined between 1976 and 1979 (because of publicity about the dangers of oral contraceptives?) and increased in the early 1980's. Use of withdrawal declined slightly in the early 1970's but increased by almost half between 1976 and 1979. Use of the diaphragm and foam has increased steadily since the mid 1970's. Condom use decreased in the early 1970's, increased in the late 1970's and in 1987 the National Research Council said it had "leveled off" (Hayes, p. 49).

Very young teens, however, are slow to adopt contraceptives. In 1982, only one quarter (23 percent) of sexually active girls under 15 used a contraception within the first month after sexual debut, compared with more than one half (53 percent) of those aged 18 and 19. More than two fifths (42 percent) of sexually active teens under 15 did not start contraceptive use for more than a year, compared to 15 percent of those 18 and 19. Researchers at the National Institute of Child Health and Human Development in Washington, D.C. and the University of North Carolina at Chapel Hill report that as more and more young teenagers, especially under age 16, become sexually active, they face "extremely high" risks of pregnancy (Hofferth et al, pp. 46 and 53).

Pregnancy rates among all adolescents have increased. They have decreased among sexually active adolescents. So many more adolescents are having intercourse that, by sheer weight of numbers, pregnancy rates among all adolescents are increasing. At the same time, pregnancy rates among sexually active teenagers are declining, a phenomenon researchers at the National Institute of Child Health and Human Development in Washington D.C. attribute to use of contraceptives (Hofferth et al, p. 46). Similarly, the National Research Council finds the rise in pregnancy "modest" compared with the rise in sexual activity "largely because of increased use of contraceptives" (Hayes, p. 52). The statistics:

* For every one thousand sexually active U.S. women 15 to 19, there were 258 pregnancies in 1973, 245 pregnancies in 1980 and 233 pregnancies in 1984 (Pittman 1988, p. 14).

* The overall teen pregnancy rate rose from 95 pregnancies per one thousand 15-19 year old women in 1972 to 111 pregnancies in 1980 and 110 pregnancies in 1985 (Pittman 1988, p. 14 and Henshaw, p. 87).

* Researchers at the Centers for Disease Control report that from 1974 to 1980, the pregnancy rate for sexually active teens declined by 5.7 percent and increased among all women by 8.2 percent. From 1980 to 1983, the rate for sexually active teens declined by another six percent and increased by 1.6 percent among all teens (Maciak, p. 2070-1).

Adolescent birth rates are down. The increase in sexual activity and pregnancies has not led to an increase in births to teenagers. The number of births to U.S. teenagers of all ages declined by about 20 percent between 1970 and 1984. The National Research Council attributes the drop to increased use

of contraceptives in the 1970's and 1980's and an increased number of abortions in the late 1970's (Hayes, p. 53).

The largest drop in the teen birth rate was between 1974 and 1980 and it occurred among young women ages 18 and 19. In those years, the rate fell by 9.2 percent for all teen women and 20.9 percent for sexually experienced teen women. Researchers at the Centers for Disease Control believe the new option to legally abort "greatly influenced" this trend. Between 1980 and 1983, the rate fell much more slowly (by 2.3 percent for all and 6.6 percent for sexually experienced teen women) and it has remained nearly steady since 1983. The researchers attribute some of the drop in this decade to increased use of contraception (Maciak, p. 2071).

Birth rates among U.S. teens ages 15-19 by age group are described below (Monthly Vital Statistics Report, June 29, 1989):

* Among one thousand U.S. teen females, 68 had babies in 1970. By 1980, the rate was 53 births per thousand and by 1987, it was 51 births.

* Among U.S. teens ages 15 to 17, the drop was less precipitous. In 1970, there were 38.8 births per one thousand U.S. females. In 1980, the rate was 32.5 births and in 1987 it was 32 births per one thousand teens.

* Meanwhile, the rate fell considerably among 18-19 year olds. In 1970, there were 114.7 births per one thousand teen females and in 1987 there were 80.2 births per thousand teens.

Birth rates to unmarried teens are up. Births to unmarried teens increased steadily during the 1970's and the 1980's, with the greatest increases among

18-19 year old unmarried teens. Birth rates among unmarried teens, by age group (Monthly Vital Statistics Report, June 29, 1989):

* Among one thousand U.S. 15-19 year old unmarried females, 22.4 gave birth in 1970, 27.6 gave birth in 1980 and 34.1 gave birth in 1987.

* Among one thousand U.S. 15-17 year old unmarried females, 17.1 gave birth in 1970. By 1980, the rate was 20.6 per one thousand and by 1987, it was 24.5 births per one thousand teen females.

* Meanwhile, among one thousand U.S. 18-19 year old unmarried females, 32.9 gave birth in 1970, 39 gave birth in 1980 and 49.9 gave birth in 1987.

Adolescent abortion rates rose sharply after abortion became legal in 1973. Between 1973 and 1980, teen abortion rates almost doubled. In comparison, they rose less than three percent between 1980 and 1985 (Hayes reports data showing a slight decline since 1980, p. 59). About 30 percent of all abortions in the United States are performed on teenagers and 40 percent of all teenage pregnancies end in abortion. Among girls under 15, there are now 1.4 abortions for every live birth (Hayes, p. 58).

The statistics (Pittman, p. 14; Henshaw and Van Vort, p. 87):

* For every one thousand U.S. women ages 15 to 19, there were 22.8 abortions in 1973. The number rose to 43 abortions per one thousand in 1980 and stabilized at 44 abortions per one thousand in 1985.

* Among one thousand sexually active U.S. women ages 15 to 19, there were 61 abortions in 1973. By 1984, the rate had risen to 93 per thousand.

> "Continued efforts aimed both at delaying early sexual experience...and encouraging the use of contraception among sexually active teens are necessary to further reduce teen pregnancy and birth rates in this country."
>
> -- Barbara Maciak,
> Centers for Disease Control

2. The arguments against

Some argue that the statistics show that after 15 years, current efforts to curb teen pregnancy -- "modern" sex education classes, confidentiality, access to contraceptives and, most recently, school-based health clinics -- haven't worked. This section will describe the thoughts of three advocates of this position.

In an essay for the Family Research Council of Washington, D.C., Barrett Mosbacker writes that past tactics haven't worked because they are based on the principle of moral neutrality, a "kids are going to do it anyway" attitude, and reliance on birth control to reduce teen pregnancy (Mosbacker, p. 3). "We must not abandon our children to promiscuity," he writes (p. 6). "We must renew our efforts to mold their character in such a way that they reflect virtue, self control and self sacrifice in service to others."

Dinah Richards, in a monograph for the San Antonio Pregnancy Centers, concludes that "progressive" sex education has "exacerbated the problem of teenage pregnancy, abortion, STD's and psychological consequences for young people." The better solution is abstinence education, she says.

Richards says today's sex educators introduce "mature concepts" at elementary school age on the assumption that this will serve as a deterrent to adolescent pregnancy. "But the opposite situation occurs; effects can vary from removing natural sexual inhibitions, keeping sexual impulses stirred up, disrupting personal growth to the more severe effects of sociopathic behavior" (Richards, p. 7). This "falsely based" sex education is prevalent at the secondary level where it disturbs the sexual development at a critical phase, Richards writes. She elaborates (p. 7):

> "During this stage, boys' sexual energies are centered on genitalia, whereas girls' eroticism focuses...more on fantasies and dreams, kisses and caresses... A girl's natural reluctance to allow her sexual feelings to become intertwined with the sex act serves to strengthen the affectionate and spiritual nature of sex. Through chastity and spiritualization, adolescents learn to feel esteem for members of the opposite sex."

Richards believes sex educators deliberately patronize women by concealing the drawbacks of contraception. Policy makers fail to recognize that their "safe sex" approach increases psychological problems for teens who have sexual intercourse, she says. "Even ethical, well-intentioned" classroom teachers fail to inform young people about the harms of contraception, including the ten percent contraceptive failure rate among teens (Richards, p. 8). Indeed, she adds, the recent movement to promote condom use via classroom education and television advertisement "will probably be followed by an increase in the incidence and side effects of STD's" (Richards, p. 8). Finally, she quotes a joint statement by former U.S. education secretary William Bennett and Surgeon General C. Everett Koop (p. 9):

> "Young people must be told the truth -- that the best way to avoid AIDS is to refrain from sexual activity until as adults they are ready to establish a mutually faithful monogamous relationship."

Defining moral instruction as "abstinence education", Richards argues that one without the other is not "amoral" but "immoral". She attacks "contemporary" educators who she says assume that most teens are sexually active, that sexual promiscuity is irreversible, and that contraceptive programs reduce teen pregnancy, while ignoring the psychological and physical harm done by "promiscuity", contraception, abortion and venereal disease. She quotes Washington Post columnist William Raspberry ("I don't see moral instruction as offensive to anyone"), and pediatrician James Dobson ("...a well-designed sex education program...would have to incorporate more than 'how to'") (Richards, p. 11).

Richards advocates that an effective sex education course would (pp. 12-13):

- Emphasize increasing self identity
- Recognize the negative influence of the media
- Teach the importance of friendship
- Teach the difference between being liked and being popular
- Teach the difference between love and infatuation
- Teach the male and female physiology and stages of development
- Teach physical and psychological harms as a result of adolescent sexual activity
- Teach the freedoms that accompany chastity
- Teach how to say "no"
- Teach the joys and responsibilities of parenting
- Teach the effectiveness and side effects of family planning.

Richards believes that most sex education courses today "either deliberately or subliminally" endorse contraceptive use by teens. By placing family planning information in the context of the family and pointing out harms and failure rates, educators can avoid these pitfalls, she says.

Allen C. Carlson, president of the conservative Rockford Institute think tank, says studies show that introducing contraceptives to young people encourages more frequent sexual contact. "Simple immaturity" and "intense emotional drives to please boy friends and bear a child" insure some contraceptive failure and resulting pregnancy, he says (Carlson, cited in Congressional Quarterly Education Research Reports, November 11, 1988, p. 577).

In the institute's "Sensual School", Carlson writes:

> The United States is engaged in a great moral struggle, where traditional means of controlling teenage sexuality -- parental regulation of dating and courtship, religious condemnation of sex outside of marriage, informal community controls such as the shame attached to an illegitimate birth -- are being supplanted by a new social model.

Children are wholly independent moral actors in this new scheme, Carlson says. In this new world, sexual activity is accepted independently of marriage and community stigma or shame is called "illegal 'discrimination'".
Both Carlson and Mosbacker argue against school-based health clinics. "Direct evidence reveals how the new morality of the (school) birth control clinic destroys the old morality of family, church and neighborhood," Carlson argues. And thus the "true conflict" is not over birth control or school-based clinics. "Rather, it is over the morality and social norms governing family and church," Carlson says. Mosbacker says many parents believe in-school clinics usurp their authority and responsibility for helping children make decisions about sex. He calls these clinics the "latest step" in a movement to "transform public schools into social welfare agencies" (Mosbacker, p. 6).

> "The United States is engaged in a great moral struggle, where traditional means of controlling teenage sexuality...are being supplanted."
>
> -- Allen C. Carlson
> Rockford Institute

3. The arguments for

Here is summarized the thinking of six national policy groups which advocate contraceptive education and counseling in the schools.

In a 1987 study of teenage pregnancy, the National Research Council through the National Academy of Sciences offered several strategies for reducing the rate of unintended pregnancies, but made only one endorsement: to encourage contraceptive use for sexually active teenagers. In Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing, the council's Panel on Adolescent Pregnancy and Childbearing says this "surest" approach to reducing the pregnancy rate is the only one demonstrated to be effective (Hayes, p. 262). Two other strategies are suggested but not endorsed: "enhance life options" and "delay the initiation of sexual activity".

The Children's Defense Fund, urges a focus on delaying sexual activity, but says efforts would not be realistic if they did not include effective contraception among adolescents who choose to be sexually active. The defense fund implicates the "unwillingness" of the U.S. society to provide early, effective sex education in the family, the schools and the community, as well as to give sexually active teens the access they need to contraceptive services and counselling. The increasing costs of helping teen parents, make

it "clear that we need to bring this issue out of the bedroom and into the living room, the classroom, the board room, the Sunday school room" (Pittman 1986a, p. 8).

Kristin Moore and Martha Burt, writing for the Urban Institute, also recommend "sex education in a broad sense", including curricula that help teens clarify their values and goals, explore the consequences of early parenthood, develop decision-making skills and communicate with their parents. They comment that while strategy should focus on delaying pregnancy, "realistic schemes" include education on contraception for teens who have made the decision to become sexually active. They offer "few but heartfelt" recommendations: increase availability, accessibility and privacy of subsidized contraceptive services; study the impact of parental involvement and notification on use of these services; and develop new methods of contraception appropriate to teenagers' irregular patterns of sexual activity (Moore and Burt, p. 143).

The Council of State Policy and Planning Agencies in a policy manual for governors summarizes reports showing that sex education courses are effective in increasing knowledge about sexuality and contraception and do not appear to increase permissiveness in attitude or behavior. The reports show that parent-child sex education programs increase the ease and frequency of family communication about sex. The council recommends improving adolescent knowledge about sex combined with access to contraception (Foster, p. 82).

Adolescent health clinics. In 1988, the Wall Street Journal reported that there were some 120 school-based health clinics with "dozens" more planned (March 17, 1988, p. 1). The Robert Wood Johnson Foundation has helped establish more than 40 of them. A Center for Population Options study of 62 clinics in 1987 showed that about half the clinics prescribed contraceptives and a little over one fourth actually dispensed them. Another one fifth referred patients to family planning clinics (Albert and Spangler, p. 20).

Advocates of school-based health clinics believe that -- contrary to statements by those who oppose them -- clinics help prevent teen pregnancy while giving needed health care to a "medically underserved" teen population.

Adolescent medicine expert Iris Litt, M.D., writing in the Journal of the American Medical Association, says that opponents of these clinics are afraid that distributing contraceptive services encourages sexual activity among teens (Litt, p. 2230). In fact, she reports, school-based clinics find up to 90 percent of their work is basic health care for acute medical conditions.

Moreover, a two-year Johns Hopkins University study shows that students who used health clinics waited seven months longer to have sex than did their counterparts in a demographically similar school without access to a clinic. The study also concludes that the pregnancy rate at a school with a clinic fell by 30 percent. The school offering only traditional health education programs experienced a 50 percent increase (Spangler and Albert, p. 21).

The National Governors' Association reports other benefits of adolescent health clinics. It quotes two studies which show a 35 percent decline in the school dropout rate over three years after clinics were set up and a 40 percent drop in fertility rates over ten years. It says studies show reductions in absenteeism, suicide rates and drug abuse. It adds that health clinics for adolescents established across the country often provide the first comprehensive and diagnostic health care the teen may have received in years. Among the clinics' services (National Governors' Assn, p. 6):

* Comprehensive lab screenings
* Diagnosis of health disorders
* Physicals
* Examinations
* Treatment of minor injuries
* Tests and treatment for sexually transmitted diseases
* Counselling about sexuality

Comparing American and European teens. A Ford Foundation supported study by the Alan Guttmacher Institute found that European teens are more likely to use contraceptives than are their American counterparts (Jones et al, p. 53). The report found that European teens are as sexually active as American teens, begin sexual activity no earlier or later than U.S. teens, have lower abortion rates and are less likely than American adolescents to get pregnant.

> "The teen women we interviewed stated that lack of (sex) information is not the problem. Access to prevention is."
>
> -- Ketchikan Teen Pregnancy Coalition

Study director Elise Jones described the pressures of growing up in the United States where "sex is romantic but also sinful and dirty; it is flaunted but also something to be hidden" (Jones et al, p. 59):

> "American teenagers seem to have inherited the worst of all possible worlds... Movies, music radio and TV tell them that sex is romantic, exciting, titillating; premarital sex and cohabitation are visible ways of life among the adults they see and hear about; their own parents or their parents' friends are divorced or separated but involved in sexual relationships."
>
> "Yet at the same time, young people get the message good girls should say no. Almost nothing that they see or hear about sex informs them about contraception or the importance of avoiding pregnancy."

Chapter VII

IDEAS

Following are brief descriptions of state and national programs to fight teen pregnancy or to help teens with children become successful parents. They include curricula, hotlines, posters, rap groups, job training, dropout prevention, health care, and much more, with funding from private and public sources. Names and addresses are included for those who might want to consider replicating an idea.

Some programs began as the brain child of one person -- the "Blueberry Muffin Club" in Connecticut is a good example -- a business leader, a philanthropist, a psychologist, a teacher or a physician. Others were group efforts. The breadth of creative solutions evident from this partial list culled from the recent literature is one clue to the urgency and complexity of the problem.

Hotline
Crittenton Services
28 Middleton Street
Nashville, Tennessee 37210

Two teen hotlines are available to Tennessee teens. Both provide sexuality, pregnancy prevention, pregnancy information and telephone counseling and referrals. Hotline counselors encourage sexually active teens to obtain family planning services. They request teens to call

back after receive the recommended assistance. Staff also help pregnant adolescents obtain adequate prenatal care. The hotline numbers are CALL FRAN and CALL GWEN.

The Children's Aid Society
Hunter College, Harlem, New York
130 E. 101 Street
New York City, New York 10029

Located in central Harlem, directed by a Hunter College professor, the program emphasizes personal development as the surest prevention for teenage pregnancy. Program officials believe low self esteem and self confidence are the primary causes of pregnancy and childbearing among inner-city teens. The Aid Society includes a family life and sex education; career and job readiness; self-esteem enrichment through the performing arts; health and medical services, sports and recreation; homework help programs; and guaranteed access to Hunter College for students who graduate from high school.

Adolescent Pregnancy and Parenting Services
Office of the Mayor
250 Broadway, Room 1412,
New York City, N.Y. 10007

This is a comprehensive, city wide effort to reduce the incidence of first pregnancies, to help teens who are already parents become independent adults and to enhance their children's growth and development. It also is aimed at preventing repeat pregnancies to teens. The office develops policies and programs, coordinates efforts of individual agencies, recommends solutions, and implements plans to address adolescent pregnancy. It is attached to the mayor's office, giving it high visibility and high priority.

Among the office's projects: family living/sex education in schools at all grade levels; an extensive media campaign; school and community health clinics for teens; job training; housing; child care for children of teens; parenting education.

New Futures School
Albuquerque Public Schools, 2120 Louisiana Boulevard N.E.
Albuquerque, N.M. 87110

An alternative school within the public school system, New Futures School offers comprehensive educational, health, counseling, vocational and child-care services for pregnant teens and teen parents. The program also operates an outreach program for alienated youths in low-income areas. It is supported by a nonprofit, community-based organization, New Futures, Inc.

The Beethoven Project
The Ounce of Prevention Fund
188 W. Randolph, Suite 2200
Chicago, Illinois 60601

The Beethoven Project provides help from early in a mother's pregnancy until the child enters kindergarten. It teaches parenting skills and emphasizes the need for both parent and child to get a basic education. It uses intensively trained community people as home visitors. The Committee For Economic Development believes the program "merits national attention and widespread replication." It is funded by Irving B. Harris, a Chicago business leader, with matching grants from the federal government, as well as help from the state and city.

The Hartford Action Plan on Infant Health, Inc.
Parisky & Daniels
140 Huyshope Avenue
Hartford, Connecticut 06106

This organization was began by Astrida Olds, a public affairs officer with Connecticut Mutual Life Insurance Company, who convened a series of 7:30 a.m. meetings with city officials, public health professionals and banking industry representatives to address Hartford's high infant mortality rate. Known as "The Blueberry Muffin Club", this group wrote a five-year plan which is managed by a public policy and management consulting firm. It has two goals: to wage a long-term community education effort on adolescent health and infant mortality issues and to improve the outcome of pregnancy by enhancing access to prenatal services. There is a 13-member board of directors.

Among the efforts: locate pregnant women and get them into early care; mobilize churches, schools, youth groups and city groups to prevent teen pregnancy; teach youth and their parents critical thinking, increase their self esteem, improve their decision making abilities; expand family life education at all grade levels. The project is described as a "replicable and unique model" to deal effectively with infant morality and adolescent pregnancy, their symptoms and causes (National League of Cities, 1987). Funding from private and public sources.

Charles Henderson Child Health Center
Troy, Alabama

The objective is to reduce teen pregnancies and insure the best possible outcome when pregnancies do occur. The program includes prenatal and child medical care; educational and vocational services; counselling to help teens with their relationships with parents and peers.

Parents Too Soon
State of Illinois

A statewide program to reduce teen pregnancy and improve health risks for pregnant teens. The program operates through community based projects and includes prenatal care and awareness education. Program evaluations show decreased low birthweight, infant mortality and pregnancies.

Exodus, Inc.
Exodus Cities in Schools
1011 West Peachtree Street
Atlanta, Georgia 30309

A dropout prevention program that builds self esteem and develops a realistic and positive view of one's future. Exodus is a private, nonprofit organization which has joined with the city's public school system to operate Cities in Schools, a national, nonprofit corporation dedicated to coordinating and delivering human services to at-risk youth and their families. Cities in Schools' address: 1023 15th Street N.W., Washington, D.C. 20005

The Atlanta project in 1986-87 reported that every $1.2 million invested annually yielded a return of from $7 to $9 million in increased tax revenues and decreased costs of welfare and incarceration. Best known of the Atlanta programs is Rich's Academy, located inside Rich's Department Store. The program began as a school of last resort for 110 students who were failing and dropping out of traditional programs. The store provides space for the school and offers part-time employment to some students. Employees volunteer to help students. Teachers and supplies are provided by the public schools. The Rich's model is being replicated by department stores in Houston and Cincinnati.

Aunt Martha's
224 Blackhawk
Park Forest, Illinois 60466

A community-based youth center with services including 24-hour crisis response, family and individual counseling, family planning clinic for teens, programs for pregnant teens, drug counselling, assistance to runaways and their families, a group home for girls, a shelter for homeless youth, employment services, GED classes, tutoring, health services, foster care, teen parenting assistance, legal services and crisis and delinquency counseling.

Among specific activities: Young people write, produce and perform skits about teen sexuality and youth responsibility. High school students and trained and employed to teach junior high students decision making skills and methods of coping with peer pressure. Funding is from private individuals, churches, service clubs, foundations, state and federal contracts, local communities and United Way.

The Rite of Passage Experience (ROPE)
Department of Youth Services
Wethersfield, Connecticut 06109

A 19-hour, six to eight week curriculum, ROPE is taught in the sixth grade. It teaches decision making, problem solving, resisting peer pressure, enhancing self esteem and increasing self awareness. It includes low-stress group problem solving exercises and ends with a final challenge (rock climbing or rappelling or a similar four to six hour outdoor challenge). Draws heavily on parents and community. Facilitators are trained by the program founder.

Yale University evaluated the program, determining that it had some positive effects on participants (increased involvement with family, attachment to school, increased "prosocial" values and decreased alienation. The program was selected by the state as a model program. It is funded by the local community and the state.

Family Life Curriculum
3801 West Braddock Road
Alexandria, Virginia 22302

Taught from kindergarten through high school in all Alexandria public schools. Begun by a group of concerned parents, the program was implemented in stages. The school system provides and pays for graduate-level teacher training for teachers; teachers are observed frequently. It is strongly supported by parents.

The Family Learning Center
Leslie Public Schools
400 Kimball Street
Leslie, Michigan 49251

Sponsored by the Leslie Public Schools, this comprehensive, integrated program focuses on high school graduation, vocational preparation, child care, parenting skills and relief from the stress that can lead to child abuse. It coordinates the services available from several state agencies. Members of the parenting teen's extended family are included in family counselling, grandparent workshops, home visits and training. The center sponsors a child care center for children up to six. A Ford Foundation grant will be used to build new classroom facilities and a learning lab and to improve child care facilities.

The Boston Compact
26 Court Street
Boston, Mass 02108

This is an effort to improve education available to Boston youth. Among the projects: A school-to-work transition effort run by the school system and the Boston Private Industry Council. It filled 2,600 summer jobs in 1986. Future plans, formed in conjunction with private industry, include changing the way schools are organized; setting up new programs in basic education; providing alternative education programs.

Teen Link
Lincoln Community Health Center
Box 52119
Durham, North Carolina 27717

Begun by a local pediatrician in response to the area's high teen pregnancy and school dropout rates and high depression and stress-related illnesses among youth. It is open to youths between 10 and 18. Participants may refer themselves.

The program uses a holistic approach to health, viewing each teenager as a person who is part of a family, who goes to school and who lives in the community. Primary health care for teens is provided at the local community health center, including pregnancy testing and contraceptive counseling and education, well-baby care, sports physicals, psychiatric evaluations, nutritional counselling and general health care. The program hosts Teen Health Night Out, to stimulate teens' interest in health related issues (700 teens registered for a recent dance and rally).

Staff includes a physician director, coordinator, a nurse, nurse practitioner, nutritionist, family health worker, community health facilitator, systems analyst, psychiatrist, counselor and secretary. It operates on a grant from the W.K. Kellogg Foundation.

Life Planning Education
Center for Population Options
1012 14th Street NW, Suite 1200
Washington, D.C. 20005

A curriculum for secondary students, Life Planning Education integrates sexuality education with vocational education. Units explore self-esteems, values, sex role stereotypes; goal-setting, decision-making and parenthood; and communication, sexuality and employment issues. It has been pilot tested in Washington, D.C., Durham, North Carolina and El Paso, Texas.

Dollar a Day
Denver, Colorado

Girls who were 15 or younger when they first got pregnant are paid one dollar day for every day they don't get pregnant again. They may, but are not forced to, attend weekly discussions on family planning issues. (They merely have to show up to collect $7 when each session starts. They are ineligible if they are pregnant.) Of the first 18 girls enrolled, only three got pregnant again over two years. The Colorado Governor's Initiative on Teen Pregnancy is using the concept in a pilot project which also requires girls to remain in school and sit through the sessions.

Posters
Children's Defense Fund
122 C Street NW
Washington, D.C. 20001

The Children's Defense Fund includes posters as part of a five-year media campaign to prevent adolescent pregnancy. Among them:

- A picture of a pregnant model is labeled, "Will your child learn to multiply before she learns to subtract?"

- A picture of a teen mother and her baby says, "It's like being grounded for 18 years".

- A home pregnancy test box is labeled , "Last year 125,000 junior high students flunked this simple test."

Posters and Commercials
National Urban League
500 East 62nd Street
New York, New York 10021

This campaign is aimed at the adolescent male. Among the posters: "Don't make a baby if you can't be a father." The campaign also features newspaper and magazine ads and a radio commercial by singers James Ingram and Howard Hewitt.

Posters
March of Dimes
1275 Mamaroneck Avenue
White Plains, New York 10605

The March of Dimes has several posters. Middle weight boxing champion Marvelous Marvin Hagler tells teen boys to "Be a champ, not a chump. Don't be a father before you're ready". The teen singing group Menudo tells teens, "Get our beat. There's time to start a family later." A third poster cautions boys, "Teen parenthood is no joke."

Posters
American Home Economics Association
2010 Massachusetts Avenue NW
Washington, D.C. 20036

One poster in this series shows a baby in a packing box. The legend: "Too bad babies don't come with directions". A second shows the profile of a pregnant girl. The wording: "This year you have an extra birthday to think about".

Teen Services Program
Grady Memorial Hospital
Box 26158
Atlanta, Georgia 30335

A curriculum to help adolescents resist social and peer pressures that lead to early sexual involvement. It reviews characteristics of relationships and suggests assertive responses to peer pressure. The program is offered in four 90-minute sessions. High school juniors and seniors can be trained to present the curricula to younger students.

Self-help Workbooks
Girls Club of America
National Resources Center
441 West Michigan Street
Indianapolis, Indiana 46202

The workbooks -- one for teen females and one for teen males -- consider the hard realities of adolescent parenting and its impact on life plans. They encourage decision making, goal setting, communication and career research skills.

Positive Images: A New Approach to Contraceptive Education
The Center for Family Life Education
575 Main Street
Hackensack, New Jersey 07601

For grades eight through 11, the curriculum helps improve communication, decision making and consumer skills, particularly about birth control. It encourages students to understand sexuality as more than sexual intercourse.

Equal Partners
11348 Connecticut Avenue
Kensington, Maryland 20895

A two-semester curriculum covering communication, anger, conflict, gender roles, family relationships, marriage, and parenting. Includes role-playing exercises, round-table discussions and writing assignments.

Teen Outreach Program
8346 Delcrest
St. Louis, Missouri 63124

This curriculum is aimed at increasing self esteem and life management skills. It requires that teens volunteer their services to a local agency each semester -- helping them see themselves as contributors to their community. Preliminary evaluations show that participants in the program (now in 24 sites) are less likely to get pregnant or fail school courses than a comparison group. The program was developed by the Danforth Foundation and the Junior League. It receives funding from the Charles Stewart Mott Foundation for a national replication effort.

Chapter VIII

WHAT STATES ARE DOING

Although teen pregnancy experts couch their recommendations in impersonal terms, they are talking about the most personal and sensitive of subjects: sex, abortion, contraception and child rearing. So emotional and complex are these issues that almost everyone has an opinion about them. How do individual states address such hot political issues?

The state strategies summarized below were collected between 1985 and 1989. The list is long and varied but not comprehensive. It is presented to show the multiplicity of options available for policy makers contemplating the problem. Readers will notice that a state's name under a strategy does not constitute an endorsement: some states specifically reject certain approaches. The list is alphabetical.

Sources for the list:

* Asta M. Kenney and Debra Somberg: "State Teenage Pregnancy Initiatives in the 1980s: An Assessment", Teenage Pregnancy in the United States, The Alan Guttmacher Institute, 1989.

  This report is up to date to December 1988. It uses as a benchmark the strategies suggested by the National Research Council in its 1987 publication Risking the Future. Researchers have collected gubernatorial, legislative and task force initiatives and compared them

to the council's suggested remedies. The Institute identifies 25 states plus the District of Columbia with comprehensive proposals addressing teen pregnancy and parenting. They are California, Colorado, Connecticut, Delaware, Illinois, Iowa, Maine, Maryland, Michigan, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin and Wyoming. The earliest initiative was issued in 1982; the majority were released during or after 1985.

* State Responses to the Teenage Pregnancy Crisis, National Institute for Adolescent Pregnancy and Family Services, Center for Research in Human Development and Education, Temple University, 1988.

This report is up to date through 1987. The Institute that year analyzed successful and unsuccessful legislative bills relating to teen pregnancy. The survey targets initiatives introduced between 1984 and 1987. It found that 36 states had introduced 121 relevant bills. Temple University has designed a model legislative package to address the problem of adolescent pregnancy. The IBM compatible computer program contains draft bills which can be used "as is" or modified.

* State Legislative Initiatives That Address the Issue of Teenage Pregnancy and Parenting, National Conference for State Legislatures, Denver, Colorado, 1985.

This list is up to date through 1985. The national conference surveyed the 50 states for teen pregnancy prevention legislative initiatives in the summer of that year. It found 46 bills, of which 13 passed. Researchers see prevention as the "core issue". They suggest sex education; school-based health clinics; contraception, abortion and medical care; and state-level coordination and funding of community-based services for pregnant and parenting teens.

* State Health Notes, Intergovernmental Health Policy Project of the George Washington University, July-August, 1989. Partial funding for the publication is from the Health Care Financing Administration, Department of Health and Human Services. The report describes laws enacted by six states to address the issues of teen pregnancy and sex education.

ABORTION SERVICES

The National Research Council finds no scientific basis for restricting the availability of abortion for adolescents. It adds that there should be "no compromise" in the medical and personal support given adolescents who have abortions. The council also cites evidence that requiring parental consent often causes teens to delay abortions "with attendant health risks". It suggests encouraging, but not requiring, parental involvement in the teen's decision-making process. The National Conference for State Legislature says bills requiring parental consent before a minor may obtain an abortion are common types of teen pregnancy-related legislation.

* Wisconsin specifically recommends a "support system" through "pregnancy termination or delivery". It also encourages but does not require parental consent.

* In Kentucky, a 1986 act states that minors must be protected "from their own immaturity" and says parental consultations are "in the best interests" of the minor. The same wording was used in a 1985 California bill which failed.

* Alabama, Nevada, Missouri and Indiana have parental consent statutes and Tennessee and West Virginia have parental notification statutes.

* In Ohio, a parental notification bill passed the assembly but was declared unconstitutional in federal court.

* An Arizona law requires minors to obtain written consent from parents or guardians before obtaining an abortion.

ABSTINENCE

The National Research Council reports little available evidence to document that abstinence programs are effective but notes that there are several approaches to help young people delay the initiation of sexual activity. This is the most widely accepted intervention among the states, according to the Guttmacher Institute, which observes, "Despite the lack of scientific evidence, all states that address pregnancy prevention are committed to programs that attempt to postpone teenage sexual activity, mostly through education" (Kenney and Somberg, 1989).

* Five states emphasize promoting abstinence. They are Missouri, North Carolina, Ohio and Utah.

* Missouri urges "parents, schools, churches, religious organizations and the community teach abstinence and promote chastity to decrease/eliminate premarital sex and marital infidelity." It recommends programs for improving family communication skills that help promote adolescent responsibility. It also recommends decision-making in the community.

* Ohio gives funding priority to programs promoting abstinence, with special emphasis on "programs that educate young men to say 'no'."

* While suggesting abstinence, family communication, family life education and accurate information, New York also recommends access to basic health care and accessible and affordable family planning. These "must be considered" in developing a community's strategy.

* See information on a 1989 Texas law stressing education for abstinence (under Sex Education).

ADOPTION

The National Research Council recommends strengthening adoption services and setting up model programs for providing care for young women who choose adoption.

* Tennessee has made adoption services a priority and recommended a community awareness campaign to promote adoption.

* Maryland recommends counseling for teen parents who choose adoption including "support, grief and adjustment counseling" and referrals to services.

* Missouri wants information about adoption included in all family life courses.

* The District of Columbia recommends that counselors be trained in the myths and realities of the adoption process and on innovative approaches

to adoption counseling. It also encourages short-term foster care until the teen is ready to care for her child.

CASE MANAGEMENT

The National Research Council suggests developing and evaluating case management programs because "many high risk adolescent parents require intensive individualized attention and care in order to have their basic needs met".

* Seventeen states recommend case management to improve coordination among support programs.

CHILD CARE

The National Research Council reports that research shows that young parents who have access to and who use child care (in their families or their community) are more likely to finish school and take a job. The care must be supportive and provide guidance for "parents who may not fully understand their roles and responsibilities". The council recommends developing model child care programs for teenage parents.

* Twenty-one states have made child care part of their teen pregnancy recommendations.

* Tennessee requires the department of education to have each local school board report on a model on-campus day care center set up by Rule High School in Knoxville. The department is told to provide technical support and services to any local board which wishes to duplicate the program.

* Connecticut and Illinois have Young Parents Program Grants authorizing the state board of education to award grants to school districts to develop or maintain education programs with day care components for parenting students.

CHILD SUPPORT ENFORCEMENT

The National Research Council encourages efforts to explore the "effects and effectiveness" of forcing teen fathers to take responsibility for their children. Ten states have recommendations on child support enforcement.

* Tennessee in 1989 enacted a law allowing for adjustment or deferral of child support obligations provided participants (under age 21 and parents of children receiving AFDC benefits) attend school and aim for a high school diploma or the equivalent, participate in job training or in a parenting skills course.

* Michigan proposes a work requirement for young fathers.

* New Jersey would provide incentives for young fathers to provide child support. It suggests that child support be tied to "parental rewards".

* New York proposes pilot projects to test the effectiveness of counseling as part of paternity adjudication.

* Maine has a priority project for teen fathers: an effort to encourage them to accept their responsibilities while continuing their education.

CONDOM DISTRIBUTION

The Alan Guttmacher Institute says no state specifically recommends distributing condoms, although the National Research Council says condom distribution is a "potentially promising" means of encouraging male involvement in pregnancy prevention. States do, however, address the issue of male responsibility:

* New York advocates funding to promote contraceptive services for males in order to combat the perception among men that family planning is a "female" issue.

* Maine recommends research in the area of male contraceptive knowledge, attitudes and practices. The proposal suggests that "most boys do not know how to use contraceptives properly and do not know whom to ask for that information".

Other sates stress the consequences of parenting a child. The District of Columbia recommends a media campaign based on the theme "Don't Make a Baby if You Can't Be a Father".

CONTRACEPTION

The only teen pregnancy prevention approach endorsed by the National Research Council is "diligent contraceptive use". States have a variety of policies addressing family planning and contraception, among them:

* Missouri recommends that public funds not be used to "promote contraception, sterilization and abortion among teenagers". The recommendation advocates chastity and assumes that teens who are sexually active are troubled. Counselors should help teens "discover the reasons they are genitally active at a young age" and help them solve their basic problems and current difficulties.

* The New York legislature appropriated $10 million for family planning (1986-1987).

* A Utah governor's task force "has serious concerns about the appropriateness and utility of promoting contraception as a substitute for sexual abstinence by teenagers." Premature sexual activity has many risks which are not mitigated by contraception. "Promoting contraceptive use (among teenagers) conveys a message of implied societal approval of sexual intercourse among teenagers."

* Wyoming has set a goal that by 1992, 95 percent of youths who request family planning services should be able to obtain them with "reasonable" ease.

* Connecticut suggests the health department guarantee confidentiality in family planning services for teens and proposes a "sensitive health care" program to provide funds for teen health care in certain situations where the adolescent cannot pay and does not wish parents or insurers to be billed.

* Maryland recommends that contraceptives be dispensed free of charge.

* Vermont recommends that "sexually active teenagers have access, without barriers, to contraceptive counseling and services" and notes that confidentiality is important. Suggests continuing education for physicians in adolescent medicine.

* In a 1985 law, Wisconsin repealed restrictions on sale of contraceptives to minors.

CONTRACEPTIVE ADVERTISING

The National Research Council recommends contraceptive advertising and a test of how it effective it is. No state follows this suggestion, according to the Guttmacher Institute. Among other ways of dealing with the question:

* Wisconsin has legislation repealing restrictions against contraceptive advertising.

* South Carolina and Delaware suggest putting advertising for contraceptive services into their statewide media campaigns. The goal of the South Carolina campaign: "The responsible use of contraception by those teenagers who are sexually active."

CONTRACEPTIVE EDUCATION

Many states recommend family life and/or sex education, the Guttmacher Institute says. Temple University remarks, however, that family planning bills have been "largely limited" to requiring parental consent before contraceptives are dispensed to a minor. The National Research Council recommends sex education that includes information on methods of contraception, their use and their availability. Among state approaches:

* Nine indicate that information on contraception should be included in sex education. They are Colorado, Iowa, Michigan, Missouri, New Jersey (beginning in the elementary school), Ohio, South Carolina, West Virginia and Wisconsin.

* Connecticut suggests contraceptive education only outside of schools (churches and youth groups).

* Colorado recommends going beyond teaching about biology of reproduction and educating students about sexually transmitted diseases, birth control and the "positive aspects of sexual abstinence". It would also provide information on adoption and abortion.

* The District of Columbia suggests that life planning classes incorporate birth control, male responsibility, paternal rights and responsibilities and child support laws.

COORDINATING EFFORTS.

The National Research Council emphasizes the need to coordinate programs and efforts. Among the ways to coordinate

* A coalition of legislators and private organizations in Maryland promotes increased spending for family planning in an effort to reduce the incidence of abortion. The proposed budget: $3.2 million. A state study says $3.50 is saved for every dollar that goes to family planning services for women under 20.)

* Delaware in 1985 set up a legislative task force on infant mortality that includes teen pregnancy.

* Connecticut in 1984 set up a Task Force on Education to Prevent Adolescent Pregnancy to examine the extent and nature of teen pregnancy. In 1985, the state set up the 20-member Teenage Pregnancy Prevention Council. Members include state agency heads, legislators and representatives of medical, social service and business communities.

* Iowa in 1986 set up an interim committee to study untimely teen pregnancies. A bill to establish a task force on adolescent pregnancy prevention passed both houses but was vetoed by the governor. The bill was described as a "political hot potato".

* A Georgia legislator in 1987 proposed for the second time a House Teenage Study Committee. The bill did not leave committee because the subject is "too sensitive for some people to deal with", the author said.

* A Louisiana bill failed to pass which would have created a special legislative task force to study teen pregnancy and recommend appropriate programs for family living, birth control and sex education.

* Tennessee in 1989 required the Task Force on Adolescent Development and Wellness to examine state programs and services and recommend ways to improve prevention and treatment for teenage pregnancy. The program also targets teen depression, substance abuse and other issues. The task force is to set up regional conferences or workshops to increase public awareness of problems associated with teen pregnancy.

* Nebraska and Nevada enacted 1989 legislation to conduct studies into teen pregnancy and substance abuse and to reducing the number of unwanted teen pregnancies.

DECISION-MAKING TRAINING

The National Research Council suggests this approach if evaluation shows that it produces results. Sixteen states recommend building this training into the curriculum. It would focus on interpersonal communication skills, problem solving and self esteem.

EDUCATIONAL SUPPORT

The National Research Council finds that "most" teens who become mothers before they graduate do not finish high school. This reduces their prospects and those of their children. The council recommends a broad array of education programs to help these teens finish their education.

* Texas in the 1989 session enacted a law allowing school districts in which at least 30 percent of students are low income to provide an integrated program of educational support for pregnant and parenting students. Cost of the new law is $10 million and districts with highest concentrations of pregnant or parenting students will have preference. The program must include counseling, job training, day care and transportation. Other key elements in the law are training in parenting skills, help in obtaining services from government agencies and prenatal and postnatal health and nutrition education.

* Eighteen states endorse programs to help pregnant and parenting teens finish school. The suggestions include establishing flexible school hours and attendance requirements, creating alternative schools, providing on-site day care, providing health care, teaching parenting and providing transportation.

* Tennessee has legislation requiring that homebound instruction be available for pregnant students. Illinois mandates home instruction for pregnant pupils up to three months following the birth of a child.

* Wisconsin recommends alternative education programs with flexible schedules and extensive outreach and remedial services.

* Maryland wants a model incentive program that rewards students for attendance and academic performance.

* California authorizes local school boars to establish adolescent parent educational opportunity programs for pregnant or parenting students.

* Illinois requires the state Board of Education to develop guidelines for educating teen parents so they can complete high school graduation

requirements. The state also authorizes the board to award grants to school districts to support programs for parenting students.

* Florida has a dropout prevention plan which encourages local school districts to establish comprehensive prevention programs for students whose needs are not met by conventional public school programs.

GRANDPARENT LIABILITY

The National Research Council explores the family's responsibility to contribute to the financial and emotional support of their children and their children's children. The council stresses that there is no data to show whether this would strengthen family bonds and stimulate emotionally supportive involvement by the parents.

* Wisconsin makes parents financially responsible for children born to their unmarried children (while the teen parent is under 18). Both sets of grandparents are required to support the infant if its parents cannot. Hawaii has adopted similar legislation. Maryland recommends drafting it and Missouri suggests studying its effectiveness.

GROUP HOMES

Although the National Research Council concentrates on keeping parenting teens in the family home (Kenney and Somberg, 1989), Temple University researchers believe that many pregnant teens simply have "no place to call home". Group

homes serve as an option for these girls, most of whom are estranged from their families and come from single parent families, the researchers say.

* Illinois provides reimbursements from the Department of Children and Family Services for the cost and care of providing facilities for housing a minor and her child.

HEALTH CARE FOR THE NEW MOTHER AND BABY

The National Research Council reports that adolescents who bear children are at "serious risk" for health and nutrition problems. In addition, the child risks physical, social and cognitive deficiencies. State approaches to this problem include:

* Twenty-one states specifically recommend early and regular prenatal care; eleven states address nutrition education, seven discuss labor and delivery services and 11 suggest pediatric services.

* Delaware suggests comprehensive prenatal care in schools and public health facilities.

* West Virginia recommends prenatal care counseling for pregnant teens and their partners.
* Maine finds a need to increased use of services by teens by locating these services in places which are accessible and familiar (such as schools). The state also suggests flexible hours of services.

* New York recommends "fully accessible health care" with initial emphasis on at-risk, pregnant and parenting teens.

IMPROVING SCHOOL PERFORMANCE

Educational opportunity and achievement may be important in helping high-risk teens develop expectations, a "sense of can-do" and basic skills. The National Research Council supports programs to improve school performance but warns that research has not specifically shown that such programs reduce teen pregnancy, the council cautions. Among state approaches:

* Wisconsin suggests assisting children long before they reach the level of academic failure that causes them to drop out.

* Maryland recommends a pilot program tying monetary incentives to good attendance, performance and avoiding pregnancy.

LIFE MANAGEMENT TRAINING

The National Research Council says this training helps teens establish goals for themselves and achieve them. Little data on the effectiveness of these programs is available, but the council suggests developing and testing the idea.

* Eight states endorse life management training. Illinois states that students should be helped to see that they can "control their destinies" and "give meaning to their lives".

LIFE OPTIONS EDUCATION

It has becoming a commonplace to observe that generations of poverty have stifled the motivation of many to delay gratification and avoid pregnancy. The National Research Council suggests life-options programs as a possible antidote, but warns that there is no scientific evidence that they are effective in reducing rates of early pregnancy. Among the approaches taken by the states:

* The District of Columbia proposes a task force to develop a life-planning curriculum for the public schools with courses ranging from occupational knowledge and career selection to sex education and responsibility. Included would be a mandatory 12th Grade class, "Making It On Your Own".

LIFE OPTIONS: TEENS WHO ARE PARENTS

The National Research Council also believes teens who are already parents need to understand they must "invest in their own futures" in order to overcome the negative effects of early child bearing. They suggest life management training, remedial education, employment programs and child care.

* Twenty three states suggest at least one approach to increasing the life options for teen parents. Most programs are school-based so they will be accessible.

MEDIA CAMPAIGNS

The National Research Council notes that public service announcements are a "potentially effective information and outreach tool". Such a tool raises consciousness about adolescent childbearing and reaches out to teens in need of health and social services, the council says. The council calls the approach "positive" but does not include it in its recommendations because it says the approach lacks sufficient evidence of effectiveness.

* Seventeen states suggest media campaigns. The majority would emphasize the responsibilities and consequences of adolescent pregnancy in an effort to promote abstinence. Some concentrate on family planning and prenatal care services. Some promote hotlines.

* Ohio has a "You Are In Control" campaign with an estimated annual budget of $300,000 to promote services ranging from prevention to case management for parenting teens.

* Vermont recommends that by 1992 all teens be aware of the consequences of sexual activity. The purpose would be to dispel the myths that babies give you the love you didn't get from your parents; that you'll get married if you get pregnant; that you can always finish school later; that it's only the girl's problem.

* Some states have a toll-free hotline to provide information and referral to teenagers (including inquiries about health, financial assistance, social services, education, substance abuse, child care).
* Seven states have suggested persuading the media to promote more positive and responsible images of relationships. They include Maine, Maryland, Missouri, New Jersey, New Mexico, Tennessee and Utah.

* The District of Columbia proposes a "Clean Up the Airwaves" campaign with the mayor making a personal appeal to radio and television station managers for "alternative or more discreet" programming.

* Maryland suggests the governor take the lead in an effort to sensitize the "consciousness" of the media and the business community, saying teens are especially vulnerable to sexually oriented entertainment and advertising.

* Tennessee has legislation establishing a toll-free line within the office of Children's Services Commission.

* Media awareness legislation in Illinois mandates the Department of Child and Family Services to develop a statewide adoption campaign aimed at pregnant teens.

PARENTING EDUCATION

The National Research Council urges that special attention be paid to parenting education for teen parents. It cites the vulnerability of children of young parents to "behavior disorders, problems in school adjustment, lower intelligence and achievement scores and retention in grade". Problems come about because of the mother's youth and lack of schooling, poor nutrition, the baby's low birthweight, poverty and living in a single parent home, council researchers say.

* Twenty states have parenting education and child development approaches in their recommendations. Maine emphasizes improving parenting skills. Maryland wants education about age-appropriate growth and development,

children's needs and how to affect their behavior. Delaware emphasizes food budgeting, purchase and preparation.

* In 1989, the Tennessee legislature approved a bill creating the Responsible Adolescent Parenting Project (Project RAP) within the Department of Human Services. It includes counseling and services for pregnant or parenting teens and others considered at high risk to become pregnant. Goals include improving parenting skills, preventing future pregnancies and completing educational opportunities. A model project since 1986, the project has served 255 teen parents. Of these, 94 percent completed their high school education or are currently in school. Only six percent have had repeat pregnancies.

PAYING FOR HEALTH SERVICES

The National Research Council finds that bureaucratic barriers keep teens from "early, regular and appropriate" care for themselves and their children.

* New York suggests adolescents in homes which receive Medicaid be given their own Medicaid card so they have easy access to health care.

* Pennsylvania recommends third party reimbursement specifically for pregnant teens.

* Maine advocates a comprehensive initiative on financing care for pregnant and parenting teens so there will be no barriers to care. The plan would look at both private insurance and public medical assistance. Maine policy makers believe that limited financial assistance for working poor families may keep teens from adequate maternity and neonatal care.

PREGNANCY TESTING AND COUNSELING

States see pregnancy testing as an entry point into prenatal care, the Guttmacher Institute says (Kenney and Somberg, et al, 1989). But the National Research Council stresses the importance of early confirmation of pregnancy and information on "the possible risks, benefits and consequences" of giving birth, abortion and adoption. States deal with the problem this way:

* Eight states suggest pregnancy testing. Approaches include a suggestion that the testing be provided in school-based clinics and that free testing be offered at all public health facilities.

* South Carolina says it will spend almost one fourth of its teen pregnancy budget for local health department officials to make monthly visits to all middle and high school students to provide family planning services and free pregnancy testing.

* Delaware sees free pregnancy testing as a means to increase the number of teen parents who get early prenatal care.

* Maine says that all legally available options should be included in pregnancy counseling. "Women should have nondirective, comprehensive counseling."

* Connecticut recommends counseling on all options. It proposes follow-up counseling for teens who select adoption or abortion.

* California restricts counseling in its Adolescent Family Life Act. It specifies that "no grant funds" may be expended for "abortions, abortion referrals or abortion counseling."

PREVENTING SUBSEQUENT BIRTHS

The National Research Council reports that 30 percent of adolescents who bear a child have another pregnancy within two years.

* Tennessee has adopted legislation directing all state administered programs to present information to teen parents on the benefits of postponing subsequent pregnancies. In addition, see 1989 Tennessee enacted legislation based on a model program in which only six percent of participants were repeat pregnancies (under Parenting).

* Six states recommend family planning services for teen parents. They are Connecticut, Illinois, Maine, New Jersey, Ohio and Texas.

* New Jersey stresses the need to provide young fathers with contraceptive information and services.

PUBLIC ASSISTANCE FOR TEEN PARENTS

The National Research Council believes AFDC regulations "constitute an incentive for a teenage mother to establish independent living arrangements, thereby undermining her family's obligation and ability to provide financial and emotional support."

* Four states recommend ensuring that federal regulations do not encourage teen mothers to leave home. They are Maine, Maryland, Missouri and New York.

* Missouri recommends that legislators revise welfare laws so "recipients who are custodial parents can collect full child support from the parent of the child." Commenting on this, the Guttmacher Institute observes that New York, on the other hand, is concerned about balancing the child's rights with the inability of many families to support them.

* Connecticut has implemented a subsidized job training program to parents or dependent children who are recipients of AFDC, under 20 and are high school dropouts.

* Four states recommend increasing AFDC. They are Colorado, Connecticut, Maine and New York.

* Five states discuss increasing transitional payments, providing more temporary assistance and the need to break down eligibility barriers. They are Delaware, Iowa, Michigan, New York and Wisconsin.

RESOLUTIONS

The formal recognition of the problem of teen pregnancy maya be the first step in finding a solution, the National Conference for State Legislatures says.

* South Carolina passed such a resolution in 1981 recognizing the seriousness of the problem, urging support to education citizens on its costs and asking to for data collection on the issue.

* Montana in 1985 passed a resolution which points out the problem, identifies comprehensive services as a solution and urges priority referral and placement for young, single, pregnant and parenting women.

ROLE MODELS

The National Research Council finds that the positive example of role models for high-risk teens may help them form "aspirations, expectations and activity patterns" that will lead to delaying pregnancy. It adds that there is very little information available on the effectiveness of these programs.

* The District of Columbia urges organizations to "adopt-a-teen".

SCHOOL-BASED CLINICS.

Temple University reports that states interested in setting up school-based clinics are using the much studied St. Paul school clinic program as a model. The National Research Council suggests supporting school-based clinics which include contraceptive care among other services offered. It states that further evidence of the effectiveness of such clinics is needed but recommends comprehensive models in schools with high-risk populations.

* Among states which recommend creating school-based clinics are: Colorado, Connecticut, Delaware (suggests a case management program to ensure care for teens at all income levels), Maine, Maryland, Michigan (recommends clinics in all middle and high schools), New Mexico, New York, North Carolina, Ohio, South Carolina, Texas and Wisconsin.

* Two states recommend study: Illinois and Vermont.

* Maryland and North Carolina recommend school-based clinics but expressly forbid contraceptive services in the clinics. Maryland says comprehensive health care must extend "beyond school-based programs" to out of school teens.

* Colorado, on the other hand, explicitly mentions contraceptive services in clinics.

* Missouri suggests that the state not fund school-based clinics.

SEX EDUCATION AND FAMILY LIFE EDUCATION

This is one of the most controversial and sensitive issues faced by policy makers addressing the problem of teen pregnancy. Temple University reports that the "majority" of family life education legislation that failed to pass did so because of "concern by a few" about public interference in family matters. The National Research Council finds that family life and sex education are less effective in reducing teen pregnancy than contraceptive education and services. Most states that address pregnancy prevention avoid the contraceptive approach, however, the Guttmacher Institute says. Topics covered may range from family relationships to drug abuse and suicide, with teen pregnancy just one topic among many (Kenney and Somberg, et al, 1989). Here is how states approach the issue:

* A Texas law enacted in 1989 requires the state Board of Education to step up efforts to make a comprehensive, age-appropriate health education curriculum. The curriculum is to stress taking responsibility for personal health and disease prevention and it is to be available to all school districts. In addition, the curriculum is to provide information on teen pregnancy, sexually transmitted diseases and substance abuse. It is to emphasize abstinence as the most effective means of preventing unwanted pregnancies and disease. Information on the consequences of sexual activity and the statistical efficacy of contraceptive methods

must be provided. Students may opt out of the classes if their parents object.

* A 1989 Tennessee law requires local education agencies in counties where pregnancy rates are higher than 19.5 pregnancies per 1,000 females aged 15-17 to implement a program of family life instruction.

* Nine states propose mandating instruction throughout the school years (although none require such a course to graduate). The nine are Colorado, Delaware, Maryland, New York, Ohio, South Carolina, Utah, Virginia and West Virginia.

* Michigan proposes incentives to localities to provide family life and sex education.

* Only nine states propose that family planning be covered in family life/sex education courses. They are Colorado, Iowa, Michigan, Missouri, New Jersey, Ohio, South Carolina, West Virginia and Wisconsin.

* Ohio suggests that human growth and development education include a requirement for community involvement in decisions about the local course of study.

* Connecticut recommends "companion courses" to help parents become more comfortable with their own sexuality and that of their children.

* The District of Columbia would want population education as part of the sex and family life education program.

* A Virginia act mandates the board of education to develop a comprehensive family life education program in public schools by 1990. It encourages parental involvement in curriculum development.

* A Tennessee act requires the state departments of education and health to provide information to teen parents about postponing subsequent pregnancies. The state has also amended a long-standing provision making it a misdemeanor to teach sex education in public schools.

YOUTH EMPLOYMENT PROGRAMS

The National Research Council suggests that the lack of meaningful employment opportunities may diminish the desire to delay parenthood but adds that employment programs have not been evaluated for effectiveness. Most of the nine states that address the question call for job training, counseling and placement for at-risk teens. This is how some handle the question:

* New Mexico rejects employment as a means of reducing teen pregnancy. It reports that employment related factors appear to be "minor or at least indirect" in the "equation" of causes.

* New York proposes employment centers within high schools.

* Connecticut models its suggestions after the Boston Job Collaboration, encouraging students to remain in school with the expectation that they will be employed when they graduate. The program would include summer and part-time jobs as well as career planning and job counseling.

* Maryland wants government agencies to develop a "bold, comprehensive" plan to alleviate the "chronic and worsening" high rate of unemployment among high-risk teens. It suggests developing a link between economic development and increased job opportunities for these adolescents.

OTHER IDEAS

* Enhance parent-child communication so parents can better communicate their values and attitudes regarding sexual behavior to their children and help them develop positive self concepts and improve their decision making skills.

* Educate parents in understanding the difficulties facing adolescents. Nine states call for this program: Connecticut, Delaware, Illinois, Iowa, Maine, Maryland, South Carolina, West Virginia and Wisconsin.

* Reach out to young men. Delaware recommends that maternity clinics create an atmosphere conducive to male participation. New Jersey suggests "support programs for teen fathers" and males at risk. They would include parenting skills, and contraceptive information.

APPENDIX I

Table 1a

Birth Rates in Alaska, the U.S. and Selected Nations

Births/All Teens	Country	Births/1,000 Female Teens	Year
One in six	Afghanistan	159.9	1979
One in seven	Honduras	137.7	1981
One in eight	Bangladesh	130.4	1981
	Guatemala	125.5	1981
One in nine	Alaska Native	110.5	1987
One in ten	Costa Rica	96.0	1984
One in 13	Greenland	74.9	1985
One in 16	Alaska	60.3	1987
	Fiji Islands	58.8	1985
One in 18	Kuwait	56.8	1984
	Rumania	56.7	1984
One in 19	Iraq	51.4	1977
One in 20	U.S.	51.1	1985
One in 21	Brazil	48.1	1984
	Alaska White	47.2	1987
One in 22	Philippines	45.8	1980
One in 23	East Germany	43.8	1985
One in 24	Thailand	41.2	1984
One in 26	Iceland	38.1	1984
One in 30	Yukon Territory	33.3	1986
One in 32	Egypt	31.0	1982
One in 34	Britain	29.5	1985
One in 37	Spain	26.7	1978
One in 38	Australia	26.5	1983
One in 43	Canada	22.8	1986
One in 52	Norway	19.2	1984
One in 55	Ireland	18.3	1984
One in 63	Belgium	15.9	1983
One in 72	Finland	13.8	1985
One in 85	Korea	11.7	1983
One in 86	France	11.6	1985
One in 90	Sweden	11.1	1985
One in 102	Denmark	9.8	1985
One in 114	Singapore	8.8	1986
One in 116	West Germany	8.6	1985
One in 147	The Netherlands	6.8	1985
One in 149	Switzerland	6.7	1985
One in 244	Japan	4.1	1985

Sources: Alaska Department of Labor; National Center for Health Statistics; Demographic Yearbook 1986, United Nations; Canadian Office of Vital Statistics.

Table 2a

U.S. and Alaska Teen Birth Rates, Ages 15-19

	Alaska			U.S.		
	All	White	Native	All	White	Black
1970	93.9	89.4	98.7	68.3	57.4	140.7
1980	63.4	53.1	97.5	53.0	44.7	100.0
1982	68.5	58.5	99.4	52.9	44.6	97.0
1984	67.0	53.4	115.0	50.9	42.5	95.7
1986	57.6	45.9	102.7	50.6	41.8	98.1
1987	60.3	47.2	110.5	51.1	41.9	100.3
Difference in rates (1970-87):						
	-33.6	-42.2	+11.8	-17.2	-15.5	-40.4

Sources: Alaska births: Vital Statistics Research, Alaska Department of Health and Social Services, June 5, 1989. Population and birth rate estimates: Division of Research and Analysis, Alaska Department of Labor. U.S. birth rates: Monthly Vital Statistics Report, National Center for Health Statistics, July 12, 1988 and June 29, 1989.

(a) For consistency, Alaska birth rates provided by the Alaska Department of Labor are used throughout this report. However, valid statistics on the subgroup of Alaska Natives, provided by the Alaska Area Native Health Service Health Statistics Section, show slightly higher numbers. Figured on a three-year average, they are as follows (Boedeker, 1989):

1980-82 -- 104.1
1981-83 -- 105.8
1982-84 -- 113.7
1983-85 -- 116.8
1984-86 -- 115.2

Table 3a

Alaska Teen Birth Rate Ages 15-19 By Age Group
On a Three-Year Average, 1982-1987

	1982-84	1983-85	1984-86	1985-87
15-19	67.3	64.3	62.0	59.5
15-17	31.9	30.6	29.5	30.1
18-19	114.6	112.6	111.4	106.5

Source: Division of Vital Statistics Research, Alaska Department of Health and Social Services and Division of Research and Analysis, Alaska Department of Labor.

Table 4a

Number of Resident Births to Alaska Adolescents, By Year, 1982-87

Age of Mother	82	83	84	85	86	87 (a)
<15	11	13	8	13	12	10
15-17	332	348	314	318	343	351
18-19	889	809	884	788	708	724
Age Unknown	3	4	2	6	3	2
Total	1,235	1,174	1,208	1,125	1,066	1,087

Source: Vital Statistics Research Division, Alaska Department of Health and Social Services, June 5, 1989.

(a) Estimated

Table 5a

Average Birth Rates by Census Area, Alaska 1985-1987 (a)

Teen Births/All Teens	Census Area	Birth Rate
One in eight	Northwest Arctic	128.5
	North Slope	118.4
One in nine	Nome	113.8
	Wade Hampton	112.7
	Dillingham	110.8
One in ten	Prince of Wales	99.6
One in 11	Yukon-Koyukuk	91.6
One in 12	Skagway	80.8
One in 14	Ketchikan	73.8
	Valdez-Cordova	71.9
One in 15	Fairbanks North Star	67.4
One in 16	Bethel	62.2
	Sitka	60.9
One in 18	Kodiak Island	56.0
One in 19	Matanuska Susitna	53.7
	Southeast Fairbanks	53.4
	Kenai Peninsula	52.8
One in 20	Anchorage	50.8
	Juneau	50.1
One in 22	Aleutian Islands	45.6
One in 23	Haines	43.0
One in 27	Wrangell-P'burg	37.4
One in 65	Bristol Bay	15.3

Source: Alaska Departments of Health and Social Services and Labor.

(a) Per 1,000 females 15-19, using state Department of Labor population estimates for 1985 and 1987 and extrapolating 1986 from those years.

Table 6a

Marital Status of Adolescent Mothers At Time of Child's Birth, By Census Area, Alaska, 1985-1987 (Averaged)

Census Area	Married	Unmarried	Percent Unmarried
NW Arctic	7	80	92
Nome	11	86	89
Yukon-Koyukuk	10	73	88
Wade-Hampton	12	83	87
North Slope	15	55	79
Skagway	7	22	75
Haines	2	6	75
Bethel	22	76	72
Dillingham	22	48	69
Ketchikan	30	62	67
Wrangell-Pburg	9	17	65
Juneau	42	79	64
Aleutians	13	22	63
Sitka	21	33	61
Valdez-Cordova	24	36	60
Kodiak	27	37	57
Anchorage	562	640	53
Mat-Su	95	99	51
Prince of Wales	20	26	47
Fairbanks NStar	258	198	43
Kenai	131	88	40
SE Fairbanks	24	10	29
Bristol Bay	2	0	00

Source: Vital Statistics Research Division, Alaska Department of Health and Social Services.

Table 7a

U.S. Mothers Younger than 20 and the Reported Age of the Fathers Of Their Children, 1983, By Age of Mother

Age of Father	All Teen Mothers Under Age 15		All Unmarried Teen Mothers Who Report Age of the Father
	Married %	Unmarried %	%
Younger than 18	19.9	11.3	48.6
18-19	31.6	7.0	30.1
20-24	37.2	4.0	17.4
25-29	6.0	0.7	2.8
30+	3.2	0.2	1.1
Not stated	2.1	76.7	
Percent of all Mothers in Marital Status	9.6	90.4	

Age of Father	All Mothers Ages 15 to 17		Unmarried Teen Mothers Age 15-17 Who Report The Age of the Father
	Married %	Unmarried %	%
Younger than 18	8.0	7.0	21.2
18-19	34.0	12.2	36.9
20-24	48.0	11.4	34.7
25-29	7.1	1.8	5.4
30+	2.2	0.6	1.8
Not stated	0.7	67.0	
Percent of all Mothers in Marital Status	32.5	67.5	

Table 7a (Continued)

Table 7a (Continued)

Age of Father	All Mothers Ages 18 and 19		Unmarried Teen Mothers Age 18-19 Who Report The Age of the Father
	Married %	Unmarried %	%
Younger than 18	1.2	1.8	5.0
18-19	17.3	9.0	24.9
20-24	63.7	18.9	52.4
25-29	13.3	4.5	12.6
30+	3.9	1.9	5.2
Not Stated	0.5	64.0	
Percent of All Mothers in Marital Status	54.3	45.7	

Adapted from Pittman, Karen, Advocate's Guide to the Numbers, Children's Defense Fund, Washington, D.C., 1988, using unpublished data from the National Center for Health Statistics.

(a) Data on the age of fathers is collected from information recorded on the birth certificate. This information not always reported.

Table 8a

Ages of Teen Parents Applying for Welfare, Alaska, January 1989

Age	Number Cases	Percent of All Cases (N=335)
19	187	56.0
18	100	30.0
17	34	10.0
16	8	2.0
15	5	1.5
14	1	1.0
13	0	0.0

Source: "Participation of Teenage Mothers in Alaska's AFDC and Food Stamp Programs", Division of Public Assistance, Alaska Department of Health and Social Services.

Table 9a

Number of Children in Teen Families Receiving AFDC, Alaska, January 1989

Children In Each Family	Families	
	Number	Percent (N=335)
1	245	73.0
2	70	21.0
Last trimester	20	6.0

Source: "Participation of Teenage Mothers in Alaska's AFDC and Food Stamp Programs", Division of Public Assistance, Alaska Department of Health and Social Services.

Table 10a

Location by Public Assistance Office of Teens Applying for Welfare, Alaska, January 1989

Area	Number Cases	Percent (N= 335)
Anchorage	148	44.2
Fairbanks	47	14.0
Kenai	27	8.0
Wasilla	26	8.0
Ketchikan	22	6.5
Bethel (SW Region)	13	3.8
Juneau	13	3.8
S.central/N.west	13	3.8
Northern Rural	7	2.0
Kotzebue	7	2.0
Nome	5	1.5
Sitka	5	1.5
Fort Yukon	2	0.6

Source: "Participation of Teenage Mothers in Alaska's AFDC and Food Stamp Programs", Division of Public Assistance, Alaska Department of Health and Social Services.

Appendix II

TABLES I to V

FORMULAS AND ASSUMPTIONS

The formulas and assumptions used to reach cost estimates in Tables I - V are patterned on methodology devised by the Center for Population Options and the Children's Defense Fund. They are described below.

A) Mothers Who Began Parenting as Teens.

Formulas to estimate costs of all mothers who began parenting as teens were devised by the Center for Population Options after review of 12 studies estimating public costs of teenage childbearing (Burt and Haffner, p. 221).

To calculate Single Year Costs, welfare costs for one year attributable to teen childbearing are added together (Medicaid, AFDC, Food Stamps). To calculate Single Birth Costs, welfare costs (Medicaid, AFDC and Food Stamps) attributable to teen childbearing are adjusted over 20 years to accommodate their anticipated failure to keep pace with inflation. They are then multiplied by the anticipated number of members of one teen family receiving benefits each year. The total is adjusted by the probability that the mother is receiving welfare and then adjusted for the discount factor. This calculation is repeated for a 20 year period and the total is multiplied by 40 percent to calculate potential savings. For Single Cohort Costs, the number of first births to teens (by age group) is multiplied by the Single Birth Cost for each age group.

The following assumptions are used with the above formulas:

* First, only first births to teens are used, although 19 percent of Alaska teens giving birth between 1982 and 1987 were having a second, third or even fourth child. It is assumed that a first birth to an adolescent triggers a chain of events, some of them involving public funds, and that second and more births are part of that chain (Burt and Haffner, p. 9).

* Second, births to all teenagers, married and unmarried, are included because teenage mothers, whether they marry or not, have a statistically higher probability of receiving welfare at some time in their lives than do women who delay childbearing. Because nearly one third of teen mothers experience a second birth within two years of the first, it is assumed that a teen family might need welfare help sometime during the 20 years after the birth of the first child (Hayes, p. 203; Burt and Haffner, p. 12).

* Third, total costs of supporting teen families while the children are growing up are discounted by the amount a dollar spent on welfare could have earned if it had, instead, been invested today (interest minus inflation). The formula assumes four percent real (after inflation) interest (Burt and Haffner, p. 11).

* Fourth, only part of these total costs would be saved if all teens delayed childbearing until their 20's because some portion of mothers will always be on welfare, no matter how old they were when their first child was born. This formula assumes a 40 percent "savings", the difference between cost of a teen birth and cost of a later birth (Burt and Haffner, p. 11).

* Fifth, the formula assumes annual benefit levels as follows (Moore, pp. 21-3):

AFDC benefits:	$2,928 per recipient
Food Stamp benefits:	$720 per family
Medicaid benefits:	$713.30 for child
	$1,741.29 for adult
Administrative costs:	12 percent of Food Stamp and AFDC benefits
	5 percent of Medicaid benefits (Burt and Haffner, p. 22).

The AFDC annual cost in this formula is probably an under estimate. It is based on monthly costs averaged among AFDC recipients of all ages and family sizes ($244 per recipient). In January 1989, however, teen families on welfare received $653 per family per month (Lomas, p. 3).

Also not included in the formula are additional costs, such as special education programs for the children of teens, remedial education for the teen parent, job training, foster care, child protective services, counseling services, child care, housing and other services.

B) Mothers Who Are Teens Today.

The formula to calculate these costs was developed by the Children's Defense Fund and published through the organization's Adolescent Pregnancy Clearinghouse.

Alaska's actual population of teen welfare parents in one month (January 1989) is multiplied by the actual annual cost of AFDC, Medicaid and Food Stamps for these families.

The following assumptions were used to draw this conclusion.

* Population. In January 1989, 335 Aid to Families with Dependent Children (AFDC) cases showed the responsible parent under 20 years of age (Lomas, 1989). This is 4.7 percent of the caseload. Because AFDC recipients move on and off the welfare rolls, more than 335 families headed by teens receive AFDC during one year.

* Welfare costs.: Public spending for the typical needy Alaska teen parent and children totals $12,160 a year -- $33 a day -- in food, medical and AFDC costs alone. Total public costs for the cohort of Alaska adolescent mothers who receive benefits in 1989 will equal about $4 million this year ($12,159 x 335 = $4,073,265). AFDC and Medicaid are 50 percent state funding and 50 percent federal funding; Food Stamps are 100 percent federal funding (Lomas, p. 3). Annual Alaska welfare costs in early 1989 included:

AFDC benefits:	$ 7,836 per family ($653/month)
Food Stamps:	$ 720 per family[1]
Medicaid:	$ 1,741 per adult (pregnancy and delivery included)
	$ 713 per child[2]
Administrative:	
AFDC:	$ 940 per family (12 percent of benefits)
Food Stamps:	$ 86 per family (12 percent of benefits)
Medicaid:	$ 123 per family (5 percent of benefits)
Total:	$12,159

[1] These are benefits averaged among all teen families. Among those which actually receive stamps, benefits average $125/month (Lomas, p. 3.)

[2] These are probably underestimates. In 1986, the average paid by Medicaid for prenatal care and delivery per woman was $4,163. Average Medicaid paid per child under six was $1,198 (Super, p. 2). Teen mothers are at risk to have difficult deliveries and sick babies. In addition, young children generally visit the physician more frequently than older children.

TABLE I

SINGLE YEAR COSTS

ESTIMATED PUBLIC EXPENDITURES IN 1988 FOR ALASKA WOMEN WHO WERE TEENS WHEN THEIR FIRST CHILD WAS BORN

Conclusions

In 1988, $51.4 million in public assistance was spent on Alaska families that were begun when the mother was a teenager. Had all these births been delayed until the mother was 20 years old or older, the public could have avoided spending $20.6 million in public assistance in 1988.

	Public Assistance Costs in 1988 For Alaska Mothers Who Were Teens When Their First Child Was Born	Estimated Savings in 1988 If These Alaska Women Had Delayed Childbearing Until Their 20's.
AFDC (incl. admin.)	$34,122,672	
Food Stamps	$ 4,798,968	
Administrative	575,876	
Medicaid	$11,302,460	
Administrative	565,123	
Total	$51,365,099	$20,546,040

Note: Assumptions are found on the following pages.

Assumptions

AFDC

a.	Alaska AFDC 1988 benefits and administration costs (Moore, p. 21).	$64,382,400
b.	Portion of 1988 AFDC caseload in which the mother began her family as a teen - national average (Burt and Haffner, p. 17).	53 percent
c.	Total 1988 AFDC costs attributable to Alaska women who were teens when they had their first child (a * b).	$34,122,672

Food Stamps

d.	Number of Alaska individuals receiving AFDC in an average month of 1988 (Moore, p. 21).	19,823
e.	Average Food Stamp allocation to Alaska AFDC individual recipients in 1988 (Moore, p. 21).	$60.42
f.	Portion of Alaska AFDC households receiving Food Stamps in 1988 (Moore, p. 21).	63 percent
g.	Total 1988 Food Stamp costs attributable to Alaska women who were teens when they had their first child (d * e * f * b) * 12.	$4,798,968

Medicaid

h.	Number of Alaska adult Medicaid recipients in an average month of 1988 eligible because of AFDC (Moore, p. 21).	6,990
i.	Average Medicaid outlay for each Alaska AFDC adult, 1988 (Moore, p. 21).	$1,741.29
j.	Number of Alaska child Medicaid recipients in an average month of 1988 eligible because they are on AFDC (Moore, p. 21).	12,833
k.	Average Medicaid outlay for each Alaska AFDC child, 1988 (Moore, p. 22).	$713.30

l.	Total 1988 Medicaid outlay attributable to Alaska women who were teens when they had their first child (h * i) + (j * k) * b	$11,302,460

Administrative costs

m.	Food Stamps administrative costs, calculated at 12 percent of 1988 Food Stamp benefits to Alaska women who were teens when they had their first child (g * .12).	$575,876
n.	Medicaid administrative costs, calculated at 5 percent of 1988 Medicaid benefits to Alaska women who were teens when they had their first child (l * .05).	$565,123
p.	Total administrative costs attributable to Alaska women who were teens when they had their first child (m + n).	$1,140,999

Total cost attributable to teenage childbearing (c + g + l + p).	$51,365,099
Potential savings if these women had delayed childbirth until their 20's (Total Cost * .40).	$20,546,040

TABLE II

(Table II is the foundation for Table III)

Column A: The year. This begins with the year the mother's first child was born -- in this case, 1988.

Column B: Mother's age. The mother's age when the first child was born. For 15-17 year olds, age begins with 17 in 1988 because, nationally, more than half of teen mothers were actually 17. For 18-19 year olds, age begins with 19 for the same reason (Burt and Haffner, p. 45).

Column C: Probability mother and child are independent. The probability that the mother and child live independently (and are therefore eligible for public support) assumes that no teen mother heads a household before age 16, than one fourth head households at age 17, one half at age 18 and all at 20 and older. These estimates are provided by the Center for Population Options (Burt and Haffner, p. 45).

Column D: Probable number of children. This is the number of children a teen mother is likely to have over the years. Estimates are provided by the Center for Population Options. They are based on Wertheimer, Richard F and Moore, Kristin A, 1982: Teenage Childbearing: Public Sector Costs, Table 20.

Column E: Average AFDC per recipient. The 1988 Aid to Families with Dependent Children (AFDC) benefit per recipient ($244.37/month) is provided by the state Department of Health and Social Services (Moore, p. 23). Future years show a decrease of 3.2 percent per year because program benefits are not expected to keep up with inflation. AFDC benefits are assumed to increase 1.8 percent per year and inflation is assumed at five percent per year. Assumptions are provided by the Center for Population Options. (Burt and Haffner, p. 49).

Column F: Average AFDC cost per child. The probable number of children (Column D) is multiplied by the average monthly cost per recipient (Column E).

Column G: Average AFDC cost per adult. The probability that a mother and child live independently, making them eligible for welfare (Column C) is multiplied by the average monthly cost per recipient (Column E.)

Column H: Annual AFDC cost per household. The average monthly AFDC cost for each child (Column F) is added to the average monthly AFDC cost for each adult (Column G) and multiplied by 12 months.

Column I: Number of recipients in a household receiving Food Stamps. The probability that the mother and child will form an independent household (Column C) is added to the probable number of children a teen mother will have in the years to come (Column D).

Column J: Average monthly Food Stamp cost per recipient. Cost of Food Stamps per recipient ($60/month) is provided by the state Department of Health and Social Services (Moore, 1989). Future years show a decrease of 3 percent in purchasing power each year, assuming that Food Stamp benefits will increase an average of two percent per year while inflation is five percent per year. Assumptions are provided by the Center for Population Options (Burt and Haffner, p. 49).

Column K: Percent of AFDC recipients who receive Food Stamps. This estimate is provided by the state Department of Health and Social Services (Moore, p. 21). The national estimate is 75 percent (Burt and Haffner, p. 48).

Column L: Annual Food Stamp cost per household. The probable number of recipients (Column I) is multiplied by the average monthly Food benefit per recipient (Column J). This total is multiplied by the participation rate (Column K) and the result is multiplied by 12 months.

Column M: Cost of Medicaid per child. Cost of Medicaid per child ($713.30/year) is provided by the state Department of Health and Social Services (Moore, p. 22). This covers children of all ages and is probably an under-estimate because younger children are expected to have more medical costs. The state Department of Health and Social Services reports annual Medicaid costs of $1,198 per child under six in 1986. It does not decrease in the future, as AFDC and Food Stamps do on this spreadsheet, because Medicaid benefits are expected to keep pace with inflation (Burt and Haffner, p. 50).

Column N: Annual Medicaid costs for children in a family begun by a teen. Medicaid costs for an individual child (Column M) are multiplied by the probable number of children over the years in a family begun by a teen (Column D).

Column O: Cost of Medicaid per adult. Cost of Medicaid per adult ($1741.29/year) is provided by the state Department of Health and Social Services (Moore, p. 21). These figures do not decrease in the future, as AFDC and Food Stamps do on this spreadsheet, because

Medicaid benefits are expected to keep pace with inflation (Burt and Haffner, p. 50).

Column P: Annual Medicaid costs for the adult in a family begun by a teen. Medicaid costs for the individual adult (Column O) are multiplied by the probability that the adult will form an independent household, making her eligible for welfare (Column C).

Column Q: Cost of pregnancy and birth. The average cost of prenatal care and delivery was $4,163 per pregnant woman on Medicaid in 1986 (Super, p. 2). This would equal $4,417 in 1988, assuming inflation of three percent per year. In an effort to remain conservative, this average cost is the cost used for the most expensive deliveries -- those to younger teens. Actual perinatal costs to these younger mothers may be much higher. Costs for each age group and for future years are based on a Center for Population Options formula reflecting the likelihood the mother will have children in the future (Burt and Haffner, Worksheet B).

Column R: Annual Medicaid cost per household. The annual cost of Medicaid for children (Column N) is added to the annual cost for adults (Column P). The total is added to the cost of pregnancy and birth (Column Q).

TABLE II. Single Birth Costs: Cost of Family Begun by First Birth to One Alaska Adolescent (a)

A Year	B Mother's Age	C Probability Mother/Child Are Indep	D Probable Number Children	E Average AFDC Per Recip	F Av. AFDC Cost/ Child (D*E)	G Av. AFDC Cost/ Adult (C*E)	H Annual AFDC Cost Per H-Hold (F+G)*12	I AFDC Recip Receiving Fd Stamps (C+D)
Age: -15								
1988	14	.00	1.00	244	244	0	2932	1.00
1989	15	.00	1.14	237	270	0	3236	1.14
1990	16	.00	1.28	229	293	0	3517	1.28
1991	17	.25	1.41	222	313	55	4415	1.66
1992	18	.50	1.55	215	333	107	5278	2.05
1993	19	.75	1.69	208	351	156	6081	2.44
1994	20	1.00	1.83	201	368	201	6828	2.83
1995	21	1.00	1.96	195	381	195	6913	2.96
1996	22	1.00	2.10	188	396	188	7008	3.10
1997	23	1.00	2.24	182	408	182	7090	3.24
1998	24	1.00	2.38	177	420	177	7160	3.38
1999	25	1.00	2.52	171	431	171	7218	3.52
2000	26	1.00	2.66	165	440	165	7265	3.66
2001	27	1.00	2.80	160	448	160	7301	3.80
2002	28	1.00	2.88	155	446	155	7216	3.88
2003	29	1.00	2.96	150	444	150	7129	3.96
2004	30	1.00	3.04	145	441	145	7041	4.04
2005	31	1.00	3.12	141	439	141	6950	4.12
2006	32	1.00	3.20	136	435	136	6859	4.20
2007	33	1.00	3.20	132	422	132	6639	4.20

J Average Fd Stamp Per Recip	K % AFDC Who Receive Fd Stamps	L Annual Food Stamp Cost Per H-Hold (I*J*K)*12	M Cost Of Medicaid Per Child	N Annual Medicaid For Children (M*D)	O Cost Of Medicaid Per Adult	P Annual Medicaid For Adult (O*C)	Q Cost Of Preg/Birth	R Annual Medicaid Per H-Hold (N+P+Q)
60	.63	457	713	713	1741	0	4,417	5130
59	.63	505	713	813	1741	0	570	1383
57	.63	550	713	913	1741	0	570	1483
55	.63	692	713	1006	1741	435	570	2011
53	.63	829	713	1106	1741	871	477	2453
52	.63	957	713	1205	1741	1306	477	2988
50	.63	1077	713	1305	1741	1741	486	3532
49	.63	1092	713	1398	1741	1741	486	3625
47	.63	1110	713	1498	1741	1741	486	3725
46	.63	1125	713	1598	1741	1741	486	3825
45	.63	1139	713	1698	1741	1741	486	3925
43	.63	1150	713	1798	1741	1741	486	4025
42	.63	1160	713	1897	1741	1741	486	4125
41	.63	1168	713	1997	1741	1741	486	4224
39	.63	1157	713	2054	1741	1741	278	4074
38	.63	1145	713	2111	1741	1741	278	4131
37	.63	1134	713	2168	1741	1741	278	4188
36	.63	1121	713	2225	1741	1741	278	4245
35	.63	1109	713	2283	1741	1741	278	4302
34	.63	1076	713	2283	1741	1741		4024

TABLE II (Cont).

A Year	B Mother's Age	C Probability Mother/Child Are Indep	D Probable Number Children	E Average AFDC Per Recip	F Av. AFDC Cost/ Child (D*E)	G Av. AFDC Cost/ Adult (C*E)	H Annual AFDC Cost Per H-Hold (F+G)*12	I AFDC Recip Receiving Fd Stamps (C+D)
Age: 15-17								
1988	17	.25	1.00	244	244	61	3666	1.25
1989	18	.50	1.20	237	284	118	4826	1.70
1990	19	.75	1.40	229	321	172	5908	2.15
1991	20	1.00	1.59	222	352	222	6889	2.59
1992	21	1.00	1.79	215	384	215	7183	2.79
1993	22	1.00	1.99	208	413	208	7452	2.99
1994	23	1.00	2.15	201	432	201	7600	3.15
1995	24	1.00	2.33	195	453	195	7777	3.33
1996	25	1.00	2.43	188	458	188	7754	3.43
1997	26	1.00	2.57	182	469	182	7812	3.57
1998	27	1.00	2.71	177	478	177	7859	3.71
1999	28	1.00	2.82	171	482	171	7833	3.82
2000	29	1.00	2.91	165	481	165	7761	3.91
2001	30	1.00	2.99	160	479	160	7666	3.99
2002	31	1.00	3.07	155	476	155	7570	4.07
2003	32	1.00	3.15	150	473	150	7471	4.15
2004	33	1.00	3.19	145	463	145	7302	4.19
2005	34	1.00	3.20	141	450	141	7085	4.20
2006	35	1.00	3.20	136	435	136	6859	4.20
2007	36	1.00	3.20	132	422	132	6639	4.20

J Average Fd Stamp Per Recip	K % AFDC Who Receive Fd Stamps	L Annual Food Stamp Cost Per H-Hold (I*J*K)*12	M Cost Of Medicaid Per Child	N Annual Medicaid For Children (M*D)	O Cost Of Medicaid Per Adult	P Annual Medicaid For Adult (O*C)	Q Cost Of Preg/Birth	R Annual Medicaid Per H-Hold (N+P+Q)
60	.63	571	713	713	1741	435	4,064	5213
59	.63	753	713	856	1741	871	679	2405
57	.63	924	713	999	1741	1306	679	2983
55	.63	1080	713	1134	1741	1741	658	3534
53	.63	1128	713	1277	1741	1741	691	3709
52	.63	1173	713	1419	1741	1741	691	3852
50	.63	1199	713	1534	1741	1741	553	3828
49	.63	1229	713	1662	1741	1741	581	3984
47	.63	1228	713	1733	1741	1741	345	3820
46	.63	1240	713	1833	1741	1741	484	4058
45	.63	1250	713	1933	1741	1741	484	4158
43	.63	1248	713	2012	1741	1741	524	4277
42	.63	1239	713	2076	1741	1741	313	4130
41	.63	1227	713	2133	1741	1741	276	4150
39	.63	1214	713	2190	1741	1741	276	4207
38	.63	1200	713	2247	1741	1741	276	4265
37	.63	1176	713	2275	1741	1741	138	4155
36	.63	1143	713	2283	1741	1741	34	4058
35	.63	1109	713	2283	1741	1741		4024
34	.63	1076	713	2283	1741	1741		4024

TABLE II (Cont.)

A Year	B Mother's Age	C Probability Mother/Child Are Indep	D Probable Number Children	E Average AFDC Per Recip	F Av. AFDC Cost/ Child (D*E)	G Av. AFDC Cost/ Adult (C*E)	H Annual AFDC Cost Per H-Hold (F+G)*12	I AFDC Recip Receiving Fd Stamps (C+D)
Age: 18-19								
1988	19	.63	1.00	244	244	154	4780	1.63
1989	20	1.00	1.18	237	279	237	6188	2.18
1990	21	1.00	1.35	229	309	229	6457	2.35
1991	22	1.00	1.53	222	339	222	6729	2.53
1992	23	1.00	1.69	215	363	215	6926	2.69
1993	24	1.00	1.85	208	384	208	7103	2.85
1994	25	1.00	2.01	201	404	201	7262	3.01
1995	26	1.00	2.17	195	422	195	7403	3.17
1996	27	1.00	2.33	188	439	188	7528	3.73
1997	28	1.00	2.44	182	445	182	7528	3.44
1998	29	1.00	2.52	177	445	177	7456	3.52
1999	30	1.00	2.60	171	444	171	7382	3.60
2000	31	1.00	2.68	165	443	165	7304	3.68
2001	32	1.00	2.76	160	442	160	7224	3.76
2002	33	1.00	2.80	155	434	155	7068	3.80
2003	34	1.00	2.80	150	420	150	6841	3.80
2004	35	1.00	2.80	145	407	145	6622	3.80
2005	36	1.00	2.80	141	394	141	6411	3.80
2006	37	1.00	2.80	136	381	136	6205	3.80
2007	38	1.00	2.80	132	369	132	6007	3.80

(a) Numbers have been rounded. Estimated cost of AFDC per recipient is $244.37; cost of Food Stamps per recipient is $60.42; cost of Medicaid per child is $713.30; cost of Medicaid per adult is $1741.29.

J Average Fd Stamp Per Recip	K % AFDC Who Receive Fd Stamps	L Annual Food Stamp Cost Per H-Hold (I*J*K)*12	M Cost Of Medicaid Per Child	N Annual Medicaid For Children (M*D)	O Cost Of Medicaid Per Adult	P Annual Medicaid For Adult (O*C)	Q Cost Of Preg/Birth	R Annual Medicaid Per H-Hold (N+P+Q)
60	.63	745	713	713	1741	1097	3,092	4902
59	.63	966	713	842	1741	1741	569	3152
57	.63	1010	713	963	1741	1741	538	3242
55	.63	1055	713	1091	1741	1741	569	3402
53	.63	1088	713	1205	1741	1741	504	3451
52	.63	1118	713	1320	1741	1741	504	3565
50	.63	1145	713	1434	1741	1741	504	3679
49	.63	1170	713	1548	1741	1741	504	3793
47	.63	1335	713	1662	1741	1741	504	3907
46	.63	1195	713	1740	1741	1741	346	3828
45	.63	1186	713	1798	1741	1741	254	3792
43	.63	1176	713	1855	1741	1741	254	3849
42	.63	1166	713	1912	1741	1741	254	3906
41	.63	1156	713	1969	1741	1741	254	3964
39	.63	1133	713	1997	1741	1741	127	3865
38	.63	1099	713	1997	1741	1741		3739
37	.63	1066	713	1997	1741	1741		3739
36	.63	1034	713	1997	1741	1741		3739
35	.63	1003	713	1997	1741	1741		3739
34	.63	973	713	1997	1741	1741		3739

TABLE III

SINGLE BIRTH COSTS

COST OVER 20 YEARS OF EACH FIRST BIRTH TO AN ALASKA TEEN IN 1988

Conclusions

The Average Teen Family:

The family begun by one Alaska teen in 1987 will cost the public $24,000 over the next 20 years (in 1988 dollars). If this birth had been delayed until the mother was an adult, the public would have saved $9,600 over the next 20 years (in 1988 dollars).

	Cost Over 20 Years Of Each Alaska Family Begun in 1988 by a Mother in Her Teens In 1988 Dollars	Potential Savings If The Teen Birth Were Delayed In 1988 Dollars
Age 15 and under	$31,403	$12,561
Age 15-17	$31,513	$12,605
Age 18-19	$19,836	$ 7,934

Note: Assumptions are found below.

Assumptions

Column AA: The year. This begins with the year the mother's first child was born, in this case, 1988.

Column BB: Mother's age. The mother's age when the first child was born. For 15-17 year olds, age begins with 17 in 1988 because, nationally, more than half of teen mothers were actually 17. For 18-19 year olds, age begins with 19 for the same reason (Burt and Haffner, p. 45).

Column CC: Annual AFDC cost per household. This is Column H of Table II. It is the average AFDC cost per child (Column F) added to the cost per adult (Column G), multiplied by 12 months.

Column DD: Annual Food Stamp cost per household. This is Column L of Table 1. It is the number of AFDC recipients who receive Food Stamps (Column I), times the average Food Stamp benefit per recipient (Column J), times the portion of AFDC recipients who also receive Food Stamps (Column K). This total is multiplied by 12 months.

Column EE: Annual Medicaid cost per household. This is Column R of Table 1. It is the annual Medicaid cost per child (Column N) and per adult (Column P), plus the cost of pregnancy and birth (Column Q).

Column FF: Administrative costs for AFDC and Food Stamps. Estimated at 12 percent of AFDC and Food Stamp benefits. The estimate is by the Center for Population Options (Burt and Haffner, p. 61).

Column GG: Administrative costs for Medicaid. Estimated at five percent of Medicaid benefits. The estimate is by the Center for Population Options (Burt and Haffner, p. 61).

Column HH: Total public costs. This is the sum of AFDC costs (Column CC) plus Food Stamp costs (Column DD), plus medical costs (Column EE), plus social service costs (Column FF), plus administrative costs (Columns GG and HH).

Column II: Probability of receiving welfare. Not all mothers who begin their childbearing as adolescents receive public assistance. These estimates, which vary by age of the mother, are by the Center for Population Options and are based on national studies (Burt and Haffner, pp. 61-2).

Column JJ: Public cost of teen births. The total public costs (Column HH) are multiplied by the probability the woman will receive assistance (Column II).

Column KK: Discount factor. These figures are derived by assuming a four percent growth in interest (after inflation) in each dollar invested today. Each 1988 dollar is deflated ("discounted") by four percent per year. Estimate by the Center for Population Options (Burt and Haffner, p. 62).

Column LL: Yearly full (discounted) cost of one teen birth. Also known as "present value". The discount factor (Column KK) is multiplied by the cost of each birth per year (Column JJ).

Column MM: Yearly potential savings (discounted) if the teen birth had been delayed. Even if all teen births were delayed until the mother was in her 20's, some mothers would be on welfare due to other circumstance. The Center for Population Options estimates that 40 percent of current costs would be saved if all teen births were delayed (Burt and Haffner, p. 62).

TABLE III. Single Birth Cost: 20 Year Cost of Family Begun by First Birth to One Alaska Adolescent (a)

AA Year	BB Mother's Age	CC Annual AFDC Cost Per H-Hold (F+G)*12	DD Annual Food Stamp Cost Per H-Hold (I*J*K)*12	EE Annual Medicaid Per H-Hold (N+P+Q)	FF Admin Costs AFDC & Food Stamps (CC+DD)*12%	GG Admin Costs Medicaid (EE*5%)	HH Total Public Costs (Sum CC:GG)	II Probability Of Receiving Welfare	JJ Public Cost of Teen Births HH*II
Age: -15									
1988	14	2,932	457	5,130	407	257	9,183	.34	3,122
1989	15	3,236	505	1,383	449	69	5,642	.34	1,918
1990	16	3,517	550	1,483	488	74	6,112	.34	2,078
1991	17	4,415	692	2,011	613	101	7,832	.34	2,663
1992	18	5,278	829	2,453	733	123	9,416	.34	3,201
1993	19	6,081	957	2,988	845	149	11,021	.34	3,747
1994	20	6,828	1,077	3,532	949	177	12,562	.20	2,512
1995	21	6,913	1,092	3,625	961	181	12,772	.20	2,554
1996	22	7,008	1,110	3,725	974	186	13,003	.20	2,601
1997	23	7,090	1,125	3,825	986	191	13,217	.20	2,643
1998	24	7,160	1,139	3,925	996	196	13,415	.20	2,683
1999	25	7,218	1,150	4,025	1,004	201	13,598	.16	2,176
2000	26	7,265	1,160	4,125	1,011	206	13,766	.16	2,203
2001	27	7,301	1,168	4,224	1,016	211	13,921	.16	2,227
2002	28	7,216	1,157	4,074	1,005	204	13,656	.16	2,185
2003	29	7,129	1,145	4,131	993	207	13,605	.16	2,177
2004	30	7,041	1,134	4,188	981	209	13,553	.02	271
2005	31	6,950	1,121	4,245	969	212	13,498	.02	270
2006	32	6,859	1,109	4,302	956	215	13,441	.02	269
2007	33	6,639	1,076	4,024	926	201	12,865	.02	257

Yearly Costs, Savings over 20 years (1988$):

KK Discount Factor	LL Yearly Full Cost Of One Teen Birth JJ*KK	MM Yearly Potential Savings (LL*40%)
1.00	3,122	1,249
.96	1,842	737
.92	1,912	765
.89	2,370	948
.85	2,721	1,088
.82	3,073	1,229
.78	1,960	784
.75	1,916	766
.72	1,872	749
.69	1,824	730
.67	1,798	719
.64	1,392	557
.61	1,344	537
.59	1,314	526
.57	1,245	498
.54	1,176	470
.52	141	56
.50	135	54
.48	129	52
.46	118	47
	31,403	12,561

TABLE III (Cont.)

AA Year	BB Mother's Age	CC Annual AFDC Cost Per H-Hold (F+G)*12	DD Annual Food Stamp Cost Per H-Hold (I*J*K)*12	EE Annual Medicaid Per H-Hold (N+P+Q)	FF Admin Costs AFDC & Food Stamps (CC+DD)*12%	GG Admin Costs Medicaid (EE*5%)_	HH Total Public Costs (Sum CC:GG)	II Probability Of Receiving Welfare	JJ Public Cost Of Teen Births (HH*II)
Age: 15-17									
1988	17	3,666	571	5,213	508	261	10,218	.34	3,474
1989	18	4,826	753	2,405	669	120	8,774	.34	2,983
1990	19	5,908	924	2,983	820	149	10,784	.34	3,667
1991	20	6,889	1,080	3,534	956	177	12,635	.27	3,412
1992	21	7,183	1,128	3,709	997	185	13,204	.22	2,905
1993	22	7,452	1,173	3,852	1,035	193	13,704	.20	2,741
1994	23	7,600	1,199	3,828	1,056	191	13,873	.20	2,775
1995	24	7,777	1,229	3,984	1,081	199	14,270	.20	2,854
1996	25	7,754	1,228	3,820	1,078	191	14,071	.18	2,533
1997	26	7,812	1,240	4,058	1,086	203	14,399	.17	2,448
1998	27	7,859	1,250	4,158	1,093	208	14,567	.16	2,331
1999	28	7,833	1,248	4,277	1,090	214	14,662	.16	2,346
2000	29	7,761	1,239	4,130	1,080	206	14,416	.16	2,307
2001	30	7,666	1,227	4,150	1,067	208	14,318	.09	1,289
2002	31	7,570	1,214	4,207	1,054	210	14,255	.04	570
2003	32	7,471	1,200	4,265	1,041	213	14,190	.02	284
2004	33	7,302	1,176	4,155	1,017	208	13,858	.02	277
2005	34	7,085	1,143	4,058	987	203	13,476	.02	270
2006	35	6,859	1,109	4,024	956	201	13,148	.02	263
2007	36	6,639	1,076	4,024	926	201	12,865	.02	257

Yearly Costs, Savings over 20 years (1988$):

KK Discount Factor	LL Yearly Full Cost Of One Teen Birth (JJ*KK)	MM Yearly Potential Savings (LL*40%)
1.00	3,474	1,390
.96	2,864	1,146
.92	3,373	1,349
.89	3,036	1,215
.85	2,469	988
.82	2,247	899
.78	2,164	866
.75	2,141	856
.72	1,824	729
.69	1,689	676
.67	1,562	625
.64	1,501	601
.61	1,407	563
.59	760	304
.57	325	130
.54	153	61
.52	144	58
.50	135	54
.48	126	50
.46	118	47
	31,513	12,605

TABLE III (Cont.)

AA Year	BB Mother's Age	CC Annual AFDC Cost Per H-Hold (F+G)*12	DD Annual Food Stamp Cost Per H-Hold (I*J*K)*12	EE Annual Medicaid Per H-Hold (N+P+Q)	FF Admin Costs AFDC & Food Stamps (CC+DD)*12%	GG Admin Costs Medicaid (EE*5%)_	HH Total Public Costs (Sum CC:GG)	II Probability Of Receiving Welfare	JJ Public Cost Of Teen Births (HH*II)
Age: 18-19									
1988	19	4,780	745	4,902	663	245	11,335	.34	3,854
1989	20	6,188	966	3,152	858	158	11,322	.24	2,717
1990	21	6,457	1,010	3,242	896	162	11,768	.15	1,765
1991	22	6,729	1,055	3,402	934	170	12,290	.15	1,843
1992	23	6,926	1,088	3,451	962	173	12,599	.15	1,890
1993	24	7,103	1,118	3,565	987	178	12,951	.15	1,943
1994	25	7,262	1,145	3,679	1,009	184	13,279	.12	1,593
1995	26	7,403	1,170	3,793	1,029	190	13,585	.09	1,223
1996	27	7,528	1,335	3,907	1,064	195	14,029	.09	1,263
1997	28	7,528	1,195	3,828	1,047	191	13,788	.09	1,241
1998	29	7,456	1,186	3,792	1,037	190	13,661	.09	1,229
1999	30	7,382	1,176	3,849	1,027	192	13,627	.06	818
2000	31	7,304	1,166	3,906	1,016	195	13,589	.03	408
2001	32	7,224	1,156	3,964	1,006	198	13,548	.03	406
2002	33	7,068	1,133	3,865	984	193	13,243	.03	397
2003	34	6,841	1,099	3,739	953	187	12,819	.03	385
2004	35	6,622	1,066	3,739	923	187	12,537	.03	376
2005	36	6,411	1,034	3,739	893	187	12,264	.03	368
2006	37	6,205	1,003	3,739	865	187	11,999	.03	360
2007	38	6,007	973	3,739	838	187	11,743	.03	352

Yearly Costs, Savings over 20 years (1988$):

(a) Numbers have been rounded.

KK Discount Factor	LL Yearly Full Cost Of One Teen Birth (JJ*KK)	MM Yearly Potential Savings (LL*40%)
1.00	3,854	1,542
.96	2,609	1,043
.92	1,624	650
.89	1,641	656
.85	1,606	643
.82	1,593	637
.78	1,243	497
.75	917	367
.72	909	364
.69	856	343
.67	824	330
.64	523	209
.61	249	99
.59	240	96
.57	226	91
.54	208	83
.52	196	78
.50	184	74
.48	173	69
.46	162	65
	19,836	7,934

TABLE IV

SINGLE COHORT COSTS

COSTS OVER 20 YEARS OF ALL FIRST BIRTHS TO ALASKA TEENS

IN ONE YEAR

Conclusions

All families begun by Alaska teens in 1987 will cost the public $21.5 million over the next 20 years (in 1988 dollars). If these births had been delayed until the mother was an adult, the public would have saved $8.6 million over the next 20 years (in 1988 dollars).

	Single Birth		All Births	
	Cost ($)	Savings ($)	Cost ($)	Savings ($)
1987	24,187	9,675	21,478,233	8,591,293
1986	24,285	9,714	21,152,486	8,461,994
1985	23,788	9,515	20,933,851	8,373,540
1984	23,315	9,326	23,548,059	9,419,224
1983	23,800	9,520	22,634,121	9,053,648
1982	23,579	9,432	23,531,690	9,412,676

Note: Assumptions are found on the following pages.

TABLE IV. Single Cohort Costs: Cost Over 20 Years Of All First Births To Alaska Teens, One Year -1988$ (a)

a Age at First Birth	b Number of First Births	c Full Cost: 1st Birth To One Teen Over 20 Yrs (Table III)	d Full Cost: All Teen 1st Births Over 20 Yrs (b*c)	e Savings: If All Teen Births Delayed (d*40%)
1987:				
14 or yngr	10	31,403	314,033	125,613
15-17	321	31,513	10,115,786	4,046,314
18-19	557	19,836	11,048,413	4,419,365
All Births	888		21,478,233	8,591,293
Single Birth			24,187	9,675
1986:				
14 or yngr	12	31,403	376,840	150,736
15-17	320	31,513	10,084,273	4,033,709
18-19	539	19,836	10,691,373	4,276,549
All Births	871		21,152,486	8,460,994
Single Birth			24,285	9,714
1985:				
14 or yngr	13	31,403	408,243	163,297
15-17	285	31,513	8,981,305	3,592,522
18-19	582	19,836	11,544,302	4,617,721
All Births	880		20,933,851	8,373,540
Single Birth			23,788	9,515

(a) Rounded numbers on this chart will not compute to totals shown here which are based on exact, unrounded figures.

TABLE IV Continued (a)

1984				
14 or yngr	8	31,403	251,227	100,491
15-17	293	31,513	9,233,412	3,693,365
18-19	709	19,836	14,063,420	5,625,368
All Births	1,010		23,548,059	9,419,224
Single Birth			23,315	9,326
1983				
14 or yngr	13	31,403	408,243	163,297
15-17	310	31,513	9,769,139	3,907,656
18-19	628	19,836	12,456,739	4,982,695
All Births	951		22,634,121	9,053,648
Single Birth			23,800	9,520
1982				
14 or yngr	10	31,403	314,033	125,613
15-17	310	31,513	9,769,139	3,907,656
18-19	678	19,836	13,448,517	5,379,407
All Births	998		23,531,690	9,412,676
Single Births			23,579	9,432

(a) Rounded numbers on this chart will not compute to totals shown here which are based on exact, unrounded figures.

Assumptions

Column a: Mother's age, first births only. Data provided by Department of Health and Social Services (July 6, 1989). First births only are considered because a chain of events, some involving public funds, is set in motion when a first baby is born. Subsequent children simply enter that chain.

Column b: Number of first births to mother in their teens. Data provided by Department of Health and Social Services (July 6, 1989).

Column c: Cost over next 20 years of first birth to teen in specified year. From Table 2, all costs for each birth (Column LL). Costs are in present 1988 value ("discounted").

Column d: Cost over next 20 years of first births to all teens in specified year. The number of first births to teens (Column b) is multiplied by the cost over next 20 years of each birth (Column c). Costs are in present 1988 value ("discounted").

Column e: Potential savings if all first births to teens were prevented. Cost of all first births (Column d) multiplied by 40 percent. The Center for Population Options estimates that 40 percent of public costs of teen pregnancy could be saved if all first births to teens were delayed until the mother was in her 20's (Burt and Haffner, 1986).

TABLE V

SINGLE YEAR COSTS: FAMILIES OF CURRENT TEENS

Conclusions

In 1989 alone, the public will pay an estimated $4 million in Aid to Families with Dependent Children, Food Stamps and Medicaid assistance to Alaska teen parents and their children.

	aa	bb	cc	dd	ee
	Annual Costs				
	AFDC	Food Stamps	Medicaid	Administrative	Total
Each Teen Family	$7,836	$720	$2,454	$1,149	$12,159
Number Cases	335	335	335	335	335
Total Cost	$2,625,060	$241,200	$822,090	$384,915	$4,073,266

Note: Assumptions are found below.

Assumptions

Column aa: AFDC benefits. The estimated average monthly Aid to Families with Dependent Children benefit amount for January 1989 is $653 per family headed by a person under age 20. Annual benefit amount: $7,836 per family. Benefit amount and household size were estimated from a sample of cases drawn at random from the January 1989 caseload listing. AFDC funding is 50 percent federal (Title IV-A) and 50 percent state match (Lomas, p. 3).

Column bb: Food Stamp benefits. The estimated average monthly Food Stamp benefit for January 1989 is $60 per family headed by a person under age 20. Annual benefit amount: $720 per family. Benefit amount and household size were estimated from a sample of cases drawn at random from the January 1989 caseload listing. Food Stamp funding is 100 percent federal. Not all Alaska teen families on welfare received Food Stamps. Among families which do, the average benefit amount is $125 per family (Lomas, p. 3).

Column cc: Medicaid benefits. The estimated annual Medicaid benefit is $713.30 per child and $1,741.29 per adult (Moore, p. 21). Total: $2,454. Benefit amounts are averaged among all welfare recipients for 1988. These are probably under-estimates. In 1986, the average Medicaid payment for prenatal care and delivery per woman was $4,163. The average Medicaid annual payment per child under six was $1,198 (Super, p. 2). Teen mothers are at greater risk than other mothers to have complicated deliveries and sick babies. Younger children see a physician more frequently than older children.

Column dd: Administrative costs. The Center for Population Options estimates administrative costs for AFDC and Food Stamps at 12 percent of benefits and for Medicaid at five percent of benefits (Burt and Haffner, p. 17).

Number of Cases. In January 1989, a total of 335 AFDC cases were identified in which the applying responsible parent was under age 20 (Lomas, p. 3).

Total Cost. Total cost equals number of cases (335) multiplied by annual cost per case.

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Boedeker, B. Alaska Area Native Health Service, Health Statistics Section, Anchorage, Alaska.

Henshaw, Stanley. Deputy Director of Research. Alan Guttmacher Institute.

Landes, Gordon. Division of Public Assistance. Alaska Department of Health and Social Services. Juneau, Alaska.

Moore, Randy. Division of Public Assistance. Alaska Department of Health and Social Services.

Murphy, Joyce. President, Board of Directors. Booth Memorial Home. Anchorage, Alaska.

Pasquale, Elisa. Alan Guttmacher Institute. New York, New York.

Scales, Peter, Ph.D. Family Connection. Anchorage, Alaska.

Scavera, Paula. Senate Advisory Council. Juneau, Alaska.

Silverman, D. Vital Statistics Research. Alaska Department of Health and Social Services. Juneau, Alaska.

Teekell, Donna. Program Director. Booth Memorial Home. Anchorage, Alaska.

Williams, Gregg. Demographer. Alaska Department of Labor. Juneau, Alaska.